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the Canadian Nurse

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VOLUME 58 • NUMBER 7

MONTREAL

JULY, 1962

HIGHLIGHTS

ROPER — Essentials of Citizenship

POOLE — Accident Prevention

MORISON — Safety is Basic

SHULL — Ethylene Oxide Sterilization

BAYNE — Philosophy of Geriatric Care

Aging — A Project Report

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Between Ourselves

This July 1st marks the 95th Anniversary of the emergence of Canada from a state of dependence as a colony to its present stature as an independent country. Those of us who claim our citizenship by virtue of having been born here tend to be very much more casual in acceptance of our rights, privileges and responsibilities than are those who have won their citizenship after a minimum of five years' residence. For instance, we would hazard a guess that very few of the latter group failed to record their vote during the federal elections last month. Those that we know were proud to be participants as Canadian citizens. What about you? Did you remember to take the time to go to the polling station to record your vote? How valid was your excuse if you did not?

That our responsibilities as citizens goes far beyond the ballot box is well illustrated in MAYOR ROPER'S lead editorial. Can you classify yourself as a "good citizen" on the basis of the points he raises?

* * *

So now it is July again. Records show that this month is the most popular choice of individuals, of whole families for that longed-for vacation. Where they may go is of less importance than that the restraints of the workaday world are thrown off. By the hundreds, by the thousands, people take to the roads going somewhere.

This exodus is so often followed by long lists of highway mishaps and fatalities, by grisly pictures of smashed cars and shattered bodies, that it almost seems as if some evil force were at work to destroy such and such a number.

No one but a psychopath would deliberately seek death and destruction, yet when head-on collisions occur on the highway, it is obvious that one car was where it should not have been. When a car goes off the road into a culvert or ends up wound around a tree, no one would dispute the fact that it was being driven at it should not have been — either too fast for the prevailing road conditions or weather or without sufficient alert attention on the part of the driver.

Thousands of people went away in their cars and returned home safely, carefully. The ones who do not return might have if they had exercised the same care, if they had not *created* fatal situations by forgetting that driving a car demands one's full attention. The smart aleck who weaves in and out of a line of traffic, who cuts in very sharply to avoid an oncoming car and gets bumped from behind, is not a psychopath seeking death. He is usually an immature driver, unfit to control such a lethal weapon as a car.

Drive thoughtfully this summer. Stay on your own side of the road and enjoy your vacation.

* * *

You will find some other thoughts on accident prevention in the articles by PAMELA POOLE and JOAN MORISON.

Because nurses have so many opportunities to teach as they work among their patients in hospital, at clinics, in the homes, and because a great many of these people expect us to know the right answers to questions respecting safety, our responsibilities for safety education and accident prevention are unlimited. Please use your opportunities effectively.

* * *

People in general have a great sensitivity to the question of aging when the shoe fits them personally. To the student nurse, the instructor who may be ten years older is aged. The instructor looks on the supervisor or the director of nursing, who has some tell-tale gray in her hair, as almost ready for the "senior citizen" group. To the average employer, a woman of over 35 is too old to be hired, especially if the business has a pension plan.

It was interesting, therefore, to edit the article on Aging prepared by the group of youngsters at Saskatoon City Hospital. Quite honestly, we took out some of the sharper barbs — perhaps because we felt they hit too close to our editorial staff. You will find it interesting reading.

COMING: SLIM CANADIANS?

Forty Canadian companies are now producing 50 anti-obesity food and drink products. Last year, they spent a million dollars advertising formula diets. Canadians spent $10 million on weight-shedding concoctions, and $20 million on appetite-depressant pills and slimming aids.

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JULY 1962

593 ESSENTIALS OF CITIZENSHIP ..... *E. E. Roper*

Dr. Roper, who delivered this address as the Archer Memorial Lecture for 1961, is the Mayor of Edmonton.

596 ACCIDENT PREVENTION ..... *P. E. Poole*

597 SAFETY IS BASIC ..... *J. D. Morison*

Miss Morison is Nursing Supervisor, Child Health Programme, University of British Columbia, Vancouver.

599 THE SCOOTER ACCIDENT ..... *C. D. Davidson*

Miss Davidson is a graduate of Calgary General Hospital, Calgary, Alta.

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603 ETHYLENE OXIDE STERILIZATION ..... *J. J. Shull*

Mr. Shull is head of the Product Development Laboratories, Wilmot Castle Company, Rochester, N.Y.

612 PHILOSOPHY OF GERIATRIC CARE ..... *J. R. D. Bayne*

Dr. Bayne is Physician-in-charge of gerontology, Ste. Anne's Veterans Hospital, Ste. Anne de Bellevue, Que.
This is part of a lecture given to the graduate nurses of the Montreal General Hospital.

614 AGING — A PROJECT REPORT

This material was prepared by students of the class of 1963 in the School of Nursing, Saskatoon City Hospital, Saskatoon, Sask.

623 ADVANCES IN DERMATOLOGICAL THERAPY .... *S. Maddin, W. D. Stewart and J. L. Danto*

The authors are dermatologists in Vancouver, B.C.

626 THE STORKS FLY HIGHER ..... *M. Madden*

Miss Madden is lecturer in obstetrics at the University of Alberta, Edmonton.

627 INTERTROCHANTERIC FRACTURED FEMUR ..... *B. Botter*

Miss Botter was a student at the Edmonton General Hospital when this study was written.

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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of The Canadian Nurse *nor of the Canadian Nurses' Association.*

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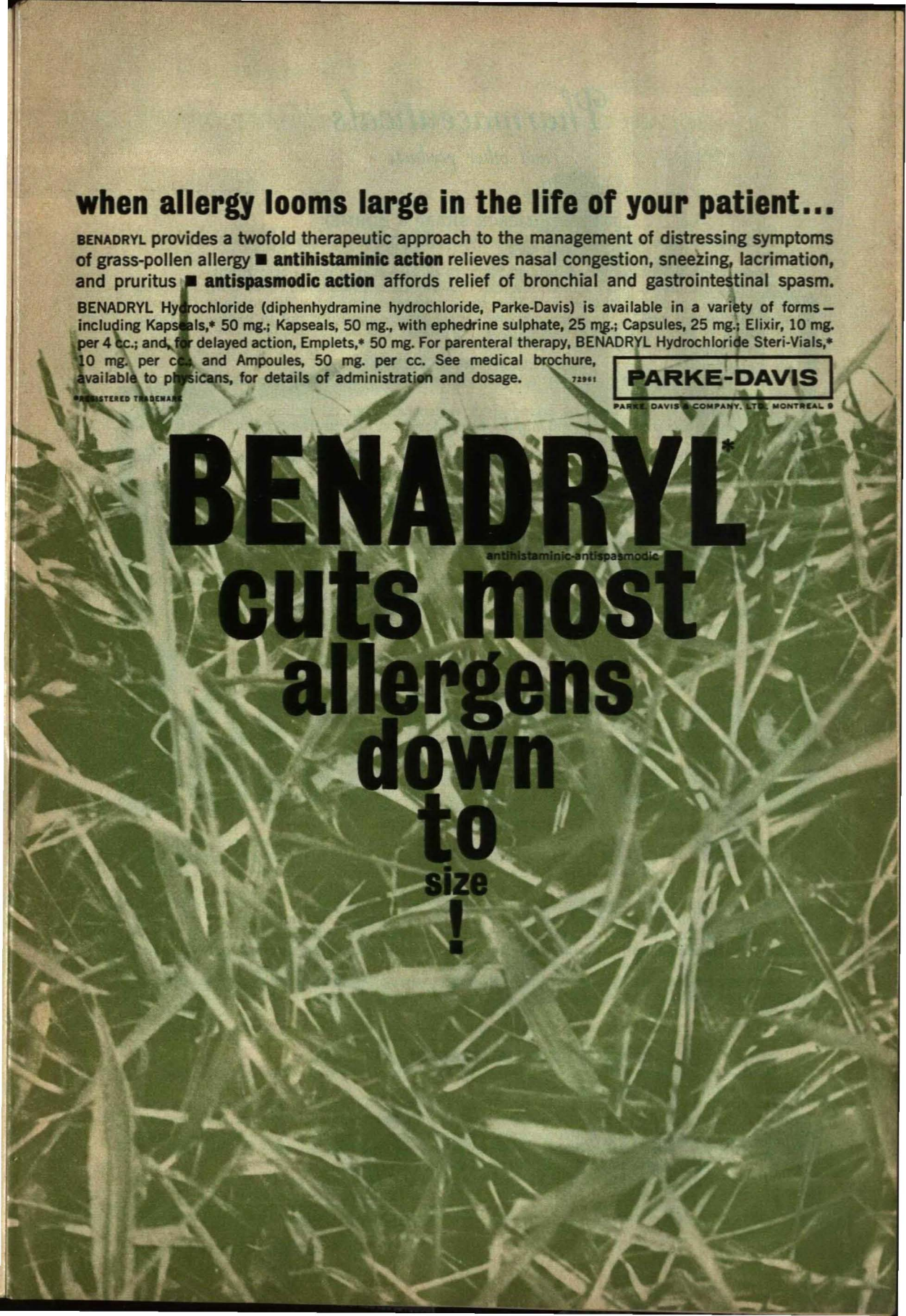
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Random Comments

Dear Editor:

At times articles are written which imply that the nurse of 20 years ago is necessarily "old-fashioned"; that she is not modern in her outlook, vital or ready to accept new ideas. In the April isue "The Impact of Change" was a most interesting article but once again the new was evident.

I suggest that any intelligent woman with an alert mind, who is practising her profession, will absorb new concepts just as readily as the younger nurse; perhaps in some cases more readily, for she has grown wisdom with the years and has learnt tolerance for the ideas of others!

I regret very much the tendency to regard her as a passing ship. For in addition to the scientific knowledge gained through constant practice she has a basic knowledge of the old concept of nursing as "nursing," and may very well combine the old graciousness with the new technical skills. Furthermore, if she is a gracious woman, and surely a nurse should be just this, she may inspire the younger nurse with her idealistic outlook; she will teach her how to give of herself. And if we cease to give of ourselves to our patients, we will truly be, not nurses, but highly-skilled technicians as has been suggested.

I feel that though it truly is difficult, we really must make time to know our patients and to listen to them; to give them the words which mean warmth and comfort of mind to them. You will not be the first to get through your long list of work but you will be truly a nurse.

Thank you for a most inspiring and interesting magazine for nurses; I am always proud and happy to pass it on to my English nurse friends after my own session of reading. MURIEL GRIFFIN, Saskatchewan

Dear Editor:

I read *The Canadian Nurse* consistently and find most articles both interesting and educational. But I am wondering how many other nurses feel as I do — that the article "Human Adaptation" in the March issue will be of very little help to me in "Understanding Patients." I couldn't even understand the article!

Also, I miss not having the biography of the author on the same page as the begin-

ning of his or her article. I think it is absolutely necessary to know the background of the writer (whether doctor, nurse, business manager, etc.) before one can get full value from any article and it is most irritating to have to continually leaf back to the index page to get this information. Why not put the sub-headings (which now appear under the title) on the index page to stimulate the interest of those who are only interested in certain subjects?

ANNA K. DAMON, British Columbia

Dear Editor:

I received your notice of Renewal of Subscription for *The Canadian Nurse*. As I am very happy about being a subscriber and really enjoy this very excellent journal I am forwarding two years' subscription.

The *Journal* has arrived very regularly and we look forward to the many splendid topics. We have read many of the topics on to the tape recorder and at our little group meetings these recordings have been a source of interest and discussion.

M. JOSEPHINE O'DWYER, Australia

Dear Editor:

Why should anyone claim credit for solving problems in obstetrics (Dec. 1961 issue) that were solved over 50 years ago? Pupil nurses were used for, rotated and placed on call for delivery 12 hours a night or day in the first decade of this century. At that period practically all O.B. cases were cared for in homes and some pupil nurses did a stint of service there.

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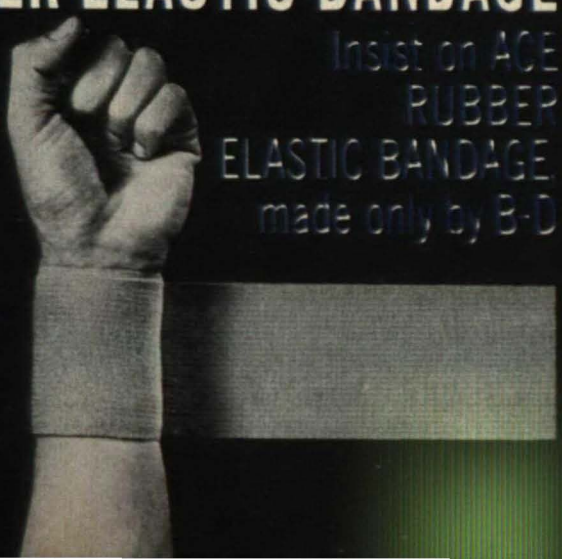

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1. Dickinson, R.L.: J.A.M.A. 128:490 (June 16) 1945. 2. Brand, E.N.: Brit. M.J. 1:24 (Jan. 5) 1952. 3. Magid, M.O., and Geiger, J.: M. Rec. 155:316 (May) 1942. 4. Thornton, M.J.: Am. J. Obst. & Gynec. 46:259 (August) 1943.

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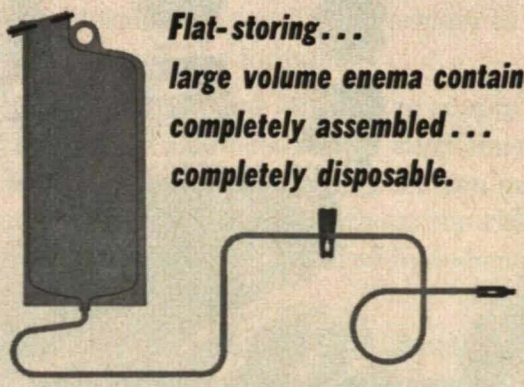

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THE CANADIAN NURSE

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ESSENTIALS OF CITIZENSHIP

THERE ARE FOUR essential responsibilities of good citizenship, whether the citizen be a doctor, a nurse, a farmer, a laborer or a man or woman of any other occupation.

1. *The good citizen will be personally responsible.* No individual can make his or her rightful contribution to society, to the life of a community or nation, unless through his working years he is prepared and willing to pull his own economic weight. Training and education play a large part in this, but only a part. More important than academic, technical or professional training is the attitude of the individual towards his personal responsibility for useful citizenship. The training and discipline acquired in a school of nursing are peculiarly effective in making people in this profession functional members of society who render valuable personal service to the life of a community.

A citizen who does not feel an obligation to do his own job well, who is not personally responsible, is not a good citizen.

2. *The good citizen will be socially responsible.* "Love thy neighbor as thyself" is an important religious precept. It is also good sound sense in a human society. The successful individual owes much to his own effort. He also owes a great debt to many others, past and present. The only way he can pay his debt is by service to others; thought for others; protection of the rights of others; the extension of help to others who need it.

Our world has always needed, and never more than now, the positive thinking, the impelling conviction and determined action of men and women who have a sense of responsibility for the age in which they live. Every advance in human society — the abolition of slavery, the development of public health and welfare, the establishment of general education — all of these and more have come to us because there have been men and women who, by reason of the compulsion of their own ideals, or religious conviction, or hatred of injustice, or love or sympathy for those less fortunate than themselves, have set out deliberately to right some wrong, to alleviate human suffering or improve social conditions.

Little more than 100 years ago the mentally ill were chained and put in dungeons. Less than 100 years ago there were slaves on this continent. Even in my own lifetime I can recall hearing of old people going to places called workhouses or poorhouses to spend the miserable, bare years of the twilight of their lives.

All this has been changed by the development of a kind of citizenship in which social responsibility, responsibility for the welfare of others, is an essential ingredient. There are many things remaining in our society that call for a quality of citizenship that is compounded in large measure of love for one's neighbor. This is not something to engage only the emotions. It should challenge the intellect, because it makes sense in a society that depends for its social health on the well-being of its members.

The citizen who is not socially responsible is not a good citizen.

3. *The good citizen will be politically responsible.* Some time ago in a large western city, out of every 100 people on the voters' lists, only 17 were sufficiently interested in the affairs of their community to take the short time and little trouble to go to the polls to help choose the people who would conduct their one hundred million dollar business; be responsible for the education of their children and for local peace, order and good government. As few as 10 per cent had voted in previous years. This is sheer political irresponsibility, an abdication of the simplest duty of citizenship.

At almost every meeting of our City Council we have delegations filling the chamber to support or oppose something that is on the agenda. If 100 people are there and they are average citizens, 83 of them are people who did not care enough about their city's affairs a year ago to walk a block or two to vote.

We live in a democracy. We enjoy all the benefits of living in it. But democracy is based on, and dependent on, citizenship participation. There is something more than mere neglect or carelessness in the failure to exercise political responsibility. There is something close to dishonesty in taking the benefits of a democratic society and failing to assume the obligations of citizenship. It is stealing a ride on the democratic bus.

The citizen who is politically irresponsible is not a good citizen.

4. *The good citizen will be a responsible world citizen.* It is becoming trite to say that modern means of travel and communication have made the world a community. What happens in India or Indonesia this morning is reported in our afternoon newspapers. Whether we like it or not, in a very real sense we are rubbing shoulders with men on the streets of Calcutta or in the bushland of Nigeria. Their problems have become our problems, very much our problems. Upon the way in which these are solved may depend our very existence. Interest in and knowledge of the rest of the world and its peoples — two-thirds of whom have colored skins — is not just an intellectual exercise these days. It is a positive requirement of intelligent citizenship in a world that has become a neighborhood.

We have a striking example of the effect of right and wrong policies and attitudes on the part of the white nations, in the situation that occurred in West Africa. Our newspapers were full of the horrible happenings in the Congo. Here, the 12 million black people who make up the area's population engaged in savage tribal civil war, wreaking hate-filled vengeance against their former white rulers, not sparing even those who came to minister to them. On the other hand, we read very little about another African nation of 25 million people who obtained their independence about the same time, Nigeria. On Nigeria's independence day, we had a flag-raising ceremony at the City Hall in Edmonton. A young Nigerian, who was receiving his law training here and has since been admitted to the Alberta Bar, brought in some literature issued by the Nigerian government. It seemed to me of tremendous significance that, pictured together in one of the books was Mary Slessor, a pioneer Scottish missionary, and Lord Lugard, the wise and dedicated administrator who started Nigeria on the road to orderly self-government.

In the Congo there is bloodshed,

turmoil and hatred. In Nigeria there is peace, progress and good will. In both cases the result has been determined by the quality of world citizenship manifested by the people and governments of the dominant nations concerned.

You and I have an immense obligation to the human and other forces that have created our democratic society. The only way in which that obligation can be discharged is by giving something of ourselves back to society. Through the use of the knowledge and skill that we acquire in our training for a lifework we make a contribution to the general good. But there is more to be considered than that. Human society, and all that enters into its composition, does not evolve and progress out of struggle. It comes out of men's thoughts and aspirations. All the things which we count as good in our society, especially those things which we think of as ennobling and humanitarian, are part of our way of life because good men and women have been prepared to give an important part of themselves to humanity.

The development of a social conscience that has made care of the sick, the helpless and the aged an obligation of our modern society did not come into being by any process of involuntary evolution. We have old age pensions, for example, because there were men and women who set out deliberately and determinedly to abolish the inhumanity of the poorhouse. The institution of slavery was abolished because men were prepared to fight, and die if necessary, to preserve the freedom and dignity of other men. All that is good in our society came through good people giving liberally of themselves, of their thoughts, their time and their energy to interests other than their own.

From my own observations over the years the men and women who give most of themselves to the community in which they live enjoy more of the rich satisfactions of life than do those whose activities are bounded by the narrow confines of their own affairs.

In the land of Palestine there are two seas. In one, fish swim as they did 2000 years ago. Splashes of green adorn its banks. Trees spread their branches over the edge of it, and stretch out their thirsty roots to sip the freshness of its water. Men build their habitations on its banks, and birds, their nests. Every kind of life is happier because the sea is there.

In the other sea there is no splash of fish. No man or beast or vegetation can drink from its brackish water. Travellers through the centuries have avoided it except on urgent business. No birds dip their pinions in its bitter surface.

What is the difference between these two seas? Not the river Jordan. It empties its good fresh water into both. But out of the sea of Galilee the river flows again. Galilee passes on as much as it receives. Galilee gives, and lives. The other sea is shrewder. It hoards all it gets. It yields to no generous impulse. It gives up nothing of itself. And men call it the Dead Sea.

ELMER E. ROPER, LL.D.

Coming!

IN

AUGUST 1962

Watt — Public Relations: An Essential Activity

Laycock — Educational Needs of Handicapped Children

Kernen — Activities of the Coordinating Council on Rehabilitation

Bycroft — Rehabilitation from the Student's Viewpoint

Plus additional material

ACCIDENT PREVENTION

PAMELA E. POOLE, B.N.

For some diseases there are specific cures, but there is no immunization against accidents.

(Quoted by J. J. Holmes in Industrial Accidents and Their Prevention, *Canadian Journal of Public Health,* Vol. 52, No. 1.)

WILL YOU BE ABLE to pick up and glance at an article in the *Journal* this time next year? Perhaps not! You may be a patient in a hospital or you may have been killed during the preceding twelve months. It is an unpleasant thought but, if accident rates continue to be as high as in the past, one out of every 204 Canadians will be injured or killed in a traffic accident in 1963.[1] This proportion is frightening but it is only part of the picture. In the average year, there are more than 2000 fatal home accidents in Canada,[2] and in 1958 there were 1269 fatal industrial accidents.[3]

Nurses are very conscious of measures to prevent the two leading causes of death — cardiovascular disease and cancer. They are involved in health education programs and daily answer questions regarding cholesterol, obesity and the danger signs of cancer. But what is each of us doing to help prevent accidents? Do we really consider prevention as part of the practice of nursing? If we do, then we have a major job to accomplish in accident prevention.

> In the course of her daily work the nurse meets people of all age groups and has unlimited opportunities for including safety instructions with her regular teaching.[4]

It is understood commonly that an accident is an occurrence over which no one has control.[5] Webster's Dictionary defines an accident as "an event which takes place without one's foresight or expectation." Perhaps this definition provides a counter argument to this commonly held assumption. "Without one's foresight" implies that there was no foresight. Is it not this that supplies the control?

To cite a specific example, a recent editorial in *The Toronto Daily Star* stated that

> Across Canada last weekend 35 persons died in traffic accidents. If they all had been wearing car safety belts, statistics indicate that perhaps 17 of these victims would be alive today.[6]

Whether these 35 persons had *control* over the accidents cannot be determined here, but if they had had the *foresight* to have seat belts in their vehicles an estimated 50 per cent of them would have had *control* over their lives.

When a mother places dangerous objects out of reach of the toddler and keeps the creeping child in a playpen away from electrical wall outlets she is using foresight and hence exercising control over her child's safety.

There is something so imperative about the ringing of a telephone. What compulsion impels us to answer it often without due care to what has been interrupted? I frequently think of the instructions given me, as a student nurse, by the nursery supervisor. "When you are giving the class of new mothers a demonstration of a baby's bath, the telephone will surely ring. This is an excellent opportunity for you to teach the mothers what to do if this should happen to them." It did ring and there were a few surprised faces when I seemed to ignore it. Understanding became apparent when I suggested that if they could not, at such a moment, bundle the baby and take him to the telephone, to *let it ring.*

If all nurses were as conscious as public health nurses of the need to maintain health by the prevention of accidents as well as by the prevention of heart disease, cancer and contagious diseases, there would be fewer hospital beds occupied. From a purely economical standpoint, accidents cost Canada millions of dollars in hospital expenditures, lost manpower hours, and welfare services. The Saskatche-

wan Hospital Services Plan spent almost $2,500,000 on hospital care on accident cases in 1959.[6] It is obvious that on a nation-wide scale accident costs are exorbitant. To measure these statistics in suffering to victims and their families would be impossible but when one of our loved ones is injured or killed as the result of an accident the problem is very real.

Nurses are an important part of the health team that teaches prevention. The conscious effort of each of us is needed. Will you still be part of that health team next year when the July *Journals* are mailed or will you be part of Canada's statistics on accidents?

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SAFETY IS BASIC

JOAN D. MORISON, M.A.

Childhood accidents make headlines every day of the week. They are the chief cause of death in children under 15 years of age. This has been the case for at least the last 20 years.

IN BRITISH COLUMBIA, it is estimated that every year the risk of accidental death is 1 child in 2820 and that 1 child in 75 will require hospital treatment for an accidental injury.[2] Nurses care for children in the nursery, in hospital wards, in child health centres, in schools. What more might we be doing to prevent these accidents?

To call these occurrences *accidents*, in itself, is misleading, for generally they are *not* "events without apparent cause." A study of 100 children with burns[4] revealed that an adult was usually with the child when he was hurt; that either the object at fault was not in its usual place or else the adult did not realize that the child could reach it. A number of parents attending a Child Health Program were asked what safeguards they provided for their children. They tended to depend upon the child's activities to direct them in taking safety measures. When he rolled off the bed, he was put in a playpen; when he was found in the cleaning cupboard for the first time, the detergents were put out of reach. Statistics show that this pattern must be true generally. It is the helpless infant who is more likely to have a serious fall or to suffocate. It is the creeper and toddler who is burned or poisoned. As the child starts to play outside he encounters danger in ponds and on the street.

The slogan, "Think Ahead to Safety," is most appropriate. As the child develops and becomes more adept at getting around in his world and in satisfying his curiosity, he puts himself in dangerous situations. Accidents happen when there has been a temporary lapse in the usual safeguards, or when there has been a lack of awareness of the child's accident potential. Mass media advertising and a national safety week have their place, but the problem of accidents merits and demands continuing individual attention.

In all nursing care and health teaching situations there are safety components. It takes only a short time to point them out and to anticipate hazards with parents, in a sense to "immunize" against childhood accidents.

The nurse's care has to be safe.

Does the new mother with her first baby realize just how much a baby can wiggle and squirm? He can fall from the unprotected side of his crib in the time that it takes to pick up a diaper. In some instances, due to relaxed visiting regulations parents are able to spend much time with hospitalized children. They see that children are never left alone in a bath; that the dressing tray with solutions and scissors is placed out of reach. Many of the precautions we have learned to take in our work have become second nature to us. Our experience is worth passing on. The nurse is an accepted visitor in the home. She is being truly professional when she helps parents to see the danger spots. For instance, it is worth being a fastidious handwasher just to check on the accessibility of the medicine cabinet to a child.

People depend on nurses for a variety of information. Knowing about all of the things that the baby will do is part of enjoying him. It is hard to realize ahead of time just how quickly he can travel when he starts to creep. It is then that electrical outlets and fixtures, low cupboards containing cleaning supplies, stairways, etc. become a hazard. What a help a playpen is as a safe place to play! The older brother may feel left out with a new baby in the house. A jealous older child may be a hazard to the baby. There are many ways of helping him to realize that his position in the family is still secure. Even if the older child is not jealous he must be helped to show his interest in the newcomer in appropriate ways.

The baby is teething. Can he have aspirin? Yes, but we are so casual about our use of aspirin that *it tops the list of potential poisons.* Aspirin is left within the reach of children much too often. In the form that it is given to children it looks and tastes like candy.

When should discipline become part of the child's life? Discipline is essentially a way of learning to live comfortably with people and things. A firm "no" in potentially dangerous situations such as approaching the stove can be a reasonable beginning for discipline even with the very young child.

How can a child be kept occupied? Playing is learning — learning what he can do, how to control his body. When he is ready he learns to climb, to swim, to play safely outside, to handle scissors and tools.

When there has been an accident, people want to talk about what has happened. They can be helped to look at the sequence of events, without being made to feel guilty.

> When 18-month-old Lynn was scalded her mother telephoned the clinic to ask for advice. She took Lynn to her own doctor and later in the day the clinic nurse dropped in to see how things were. The mother said that she had had a hectic day with a fretful baby. She had been sitting in the kitchen having a cup of coffee when she heard the baby crying again. She dashed into the other room and then she heard Lynn cry out. The little girl had reached up to the table and tipped the hot coffee over onto herself. The mother had not thought the cup was within the child's reach at all. As she talked she showed that she had accepted her responsibility for the event and already was looking at her household from Lynn's point of view. She was grateful that the nurse pointed out the dangling kettle cord. She was so used to it that she had not given it any thought.

In a study of children's accidents in Vancouver[3] the public health nurse found the parents eager to talk about safety generally. The tales they told resembled little detective stories and exploded the theory that accidents just happen.

Pamphlets and posters are good props for safety teaching. They emphasize accident hazards, especially if they apply to familiar circumstances. Some discuss safety from a developmental point of view[5] others link it with such concerns as discipline.[6] The same group of mothers, questioned during the Child Health Program, knew all the right answers to the safety check list, but remarked to a student doing a separate study[1] what a good reminder the list was.

When we take the time to act safely and talk safety, this produces an impression. Safety is an attitude, a way of living — not foolishly and fearfully, but thoughtfully and confidently.

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THE SCOOTER ACCIDENT

C. DIANNE DAVIDSON

Failure to observe the rules of safe driving resulted in several months of inactivity and general discomfort.

FOURTEEN-YEAR-OLD Gregg was admitted by ambulance suffering from shock, fractures of both legs, and superficial abrasions to his forehead and hands. He had been involved in a scooter accident when he attempted to make a left hand turn, while in the right lane of traffic, and was struck by a passing car. He was very restless and apprehensive, but Demerol proved effective in relieving his discomfort. An injection of tetanus antitoxin was ordered since there was soil contamination of his wounds. However, the test dose produced a reaction, and tetanus toxoid was substituted.

Gregg was in the operating room for three hours during which he had debridement and suturing of his right thigh, application of Thomas' splints, and insertion of Steinman's pins in both legs. Following surgery he was placed on a general surgical ward. The patients were short-term, and most of them were up and about. It is easy to imagine the feelings and thoughts of an active boy suddenly deprived of his freedom, lying in bed with both legs in traction. He was very sorry for himself. Both his parents and the nursing staff realized that something had to be done to encourage him. Within a few days Gregg was transferred to the orthopedic service. In a very short time a remarkable change in his attitude occurred. He saw and talked to people who had been in hospital for long periods of time, and had made a healthy adjustment. He saw others who were in traction similar to his own or on special beds such as the Stryker frame.

> Adolescence is a period of marked physical and psychological growth. It is a conflicting trying phase of growth, and brings stresses, frustrations and anxieties as well as potentialities for pleasure, accomplishment, and self-realization.[1]

Gregg was a well-mannered, fun-loving teenager, with a lively curiosity and a developing sense of independence although at times he reverted back to childish ways. One night he was found crying because he could not sleep. Within minutes after the nurse had chatted to him he fell asleep. It seemed likely that he was troubled by the separation from his parents. He is an only child and has received all of their attention. Boys of Gregg's age do not like to show or receive affection openly but the need is still there, and it is often disguised. Gregg expressed this in a letter which he wrote to a student nurse: "I was trying to show off, so that you would like me. Sometimes I thought I had succeeded, other times I felt that I had failed."

Gregg's free time prior to admission to hospital was spent in athletics.

He was social convenor for the school athletic club, and was active in baseball, hockey and basketball. He appeared to be of above-average intelligence and was quick to learn. He was a very stimulating patient, since he was continually asking questions about his own condition or anything that caught his interest and he wanted reasonable answers. He needed good general nursing care as well as psychological support. He became very attached to his nurses.

> Self-doubts propel him in the direction of parental protection while his own inner growth forces move him in the direction of shaking off the restrictive bonds.

Gregg had a very optimistic outlook regarding his injury, although he rebelled at times which was a good sign. One afternoon he was watching the baseball game on television. Suddenly he threw his book on the floor and said, "Why did I ever own a scooter? It's all because of it that I am in here, and not out there." After talking about the accident for some time he decided that he was a lucky boy, since he would be able to continue his sports in the fall by keeping score for the games, etc.

Nursing Care

Gregg had suffered serious injuries and one of the earliest problems in his care was shock. This was effectively controlled through the use of intravenous fluids such as whole blood and five per cent dextrose and water; elevation of the foot of the bed; extra warmth; control of pain with narcotics.

His long term care presented a special nursing problem — prevention of hip contractures and decubiti. Gregg had to lie flat most of the time in order to offset the possibility of contractures. The joints of his arms were put through a normal range of motion daily and a regime of simple exercises designed to develop biceps and triceps muscles was begun. Strong arm muscles are particularly important in crutch walking. It was rather difficult for Gregg to accept the fact that he had to lie flat, which was understandable in view of his age and lively nature.

The boy was encouraged to care for himself as much as possible. This provided some exercise and was desirable psychologically.

Good skin care was essential to comfort and to the prevention of decubiti. With both legs in traction, there was little opportunity for a change in position. The Thomas' splints caused some pressure in spite of padding. Gregg developed pressure areas under the rings on the splints although these quickly healed. Deep breathing exercises and frequent back care to provide a minimal change of position were preventive measures against hypostatic pneumonia.

Good nutrition is an important factor in healing. With encouragement and explanation, Gregg ate well-balanced meals and developed considerable interest in the relationship between his diet and his progress. Extra milk was included each day — usually in the form of milkshakes — since calcium is particularly necessary in bone formation.

When the patient is a lively youngster occupational and recreational therapy become extremely important aspects of his care. Restlessness, depression or undue mischievousness are most effectively prevented when the child can be kept occupied. With the help of his teachers Gregg continued his studies in hospital. Television, reading, games of various kinds and visiting with staff members and the other patients were helpful diversions. An effort was made to provide a variety of environment by moving him out to an adjacent sunporch.

Rehabilitation

A major concern in the care of patients with fractures is rehabilitation.

> The rehabilitation process begins at the onset of illness, and includes not only the curing of illness, but the methods of preventing further disability, the management of convalescence and the ultimate return of the individual to his maximum health and efficiency.[2]

The emotional factors in long-term illness must be understood, such as the need to provide motivation towards ultimate recovery. To be successful, the family should be included in the rehabilitation plan. The overall goal is:

> To help the child to reach his optimal

state of physical, mental, and social development so that he can become the most effective member of society possible for him, both in his family and community.[3]

Gregg's prognosis appeared very good. The doctor thought that he would be in traction for about three months, to be followed by the use of a wheelchair, and eventually crutches in time to begin school with the opening of the fall term.

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OUR NEW PRESIDENT

THIRTY YEARS AGO last March, there was the usual excitement and stir around the nurses' home at Royal Victoria Hospital, Montreal, as the preparations for the graduation exercises were being made. To Edna Agnes Electa MacLennan, graduation meant the fulfilment of a long cherished dream. The career that was launched that evening has brought many opportunities, satisfactions and rewards. The highest honor and the most responsible position in Canadian nursing — the presidency of our national association — was bestowed upon Miss MacLennan at the convention last month. An interesting "first" is added. This is the first time that a representative of the Atlantic provinces has been elected to the presidency of the Canadian Nurses' Association.

A Nova Scotian by birth, Miss MacLennan had received her B.A. from Dalhousie University, Halifax, before she began her nursing career. To this she added the diploma course in teaching in schools of nursing at the McGill School for Graduate Nurses, followed eight years later by her M.A. in public health supervision from Teachers College, New York. More recently, she was made a Fellow of the American Public Health Association.

Starting as a staff nurse with Victorian Order of Nurses in Montreal, Miss MacLennan turned to teaching in the School of Nursing, Vancouver General Hospital for two years. Her preference for work in the community took her back to the V.O.N., first as a supervisor in Montreal, then as National Office supervisor in the Maritimes. In 1944, she became an assistant secretary in the National Office of the Canadian Nurses' Association, concerning herself chiefly with the development of a public relations program. Two years later, Miss MacLennan joined the faculty of the McGill School for Graduate Nurses, as assistant director, teaching courses in public health nursing. In June 1949, she became the first director of the newly organized School of Nursing, Dalhousie University, Halifax.

Nor has all of Miss MacLennan's activity in nursing been on the aca-

(Wright, Halifax)

ELECTA MACLENNAN

demic level. During the past ten years she has chaired or been a member of a wide variety of committees, both provincially and nationally. She is very familiar with the efforts being made to reach solutions to the many problems confronting both nursing education and service. A thoughtful, fluent speaker, Miss MacLennan will be an able representative of our Association in international nursing affairs. She participated in the Congress of the International Council of Nurses in Australia last year.

It is a trite saying that the busiest people always find time to do other things. Miss MacLennan has the gift of planning her activities so that she has time for that most precious of all possessions — her friends. All of us join in wishing her well in her enlarged responsibilities.

Presidents of the Canadian Nurses' Association

For the first time in its history the Canadian Nurses' Association has a nurse from the Atlantic provinces as its president. This seems an opportune time to review the names of those who have held this office since the Association was founded in 1908. All told we have had 22 presidents, nine of whom came from Ontario, five from Quebec, three from British Columbia, two from Saskatchewan and one each from Alberta, Manitoba and Nova Scotia.

PRESIDENTS of the CANADIAN NURSES' ASSOCIATION

(The province is the one in which each resided at the time she became president. Underline ones are deceased.)

1908-12	Mary Agnes Snively	Ont.
1912-14	Mary Ard Mackenzie	Ont.
1914-17	Scharley (Wright) Brown	B.C.
1917-20	Jean Gunn	Ont.
1920-22	Edith McPherson Dickson	Ont.
1922-26	Jean (Browne) Thompson	Sask.
1926-27	Flora Madeline Shaw	Que.
1927-28	Mabel F. Gray	Man.
1928-30	Mabel F. Hersey	Que.
1930-34	Florence H. M. Emory	Ont.
1934-38	Ruby M. Simpson	Sask.
1938-42	Grace M. Fairley	B.C.
1942-44	Marion Lindeburgh	Que.
1944-46	Fanny Munroe	Que.
1946-48	Rae Chittick	Alta.
1948-50	Ethel M. Cryderman	Ont.
1950-54	Helen G. McArthur	Ont.
1954-56	Gladys J. Sharpe	Ont.
1956-58	Trenna G. Hunter	B.C.
1958-60	Alice Girard	Que.
1960-62	Helen M. Carpenter	Ont.
1962-	E. A. Electa MacLennan	N.S.

NEWFOUNDLAND IN '64

At the convention of the Canadian Nurses' Association held in Banff in 1954, the fledgling Association of Registered Nurses of Newfoundland was received into full membership. To celebrate the tenth anniversary of this event, the flourishing association is to be hostess to the 1964 CNA convention in St. John's.

You will learn many interesting things about Newfoundland through these columns in the months to come. Set your sights now for a visit to the most easterly horizon in Canada in June, 1964.

* * *

Then there was the Scotsman who bought only one spur — figuring that if one side of the horse went, the other side was sure to follow.

ETHYLENE OXIDE STERILIZATION

JAMES J. SHULL

With the continuous advent of advanced surgical techniques requiring complex instruments, with the increased emphasis on control of the hospital environment, and with increasing awareness of the shortcomings of certain present and past practices in disinfection, a gap has developed in our procedures of sterilization that can not be filled by the traditional methods of steam and dry heat.

Problems in Sterilization

MANY DESIGNS of heart-lung oxygenators can not be sterilized by steam. Those that can require disassembly and post-sterilization reassembly, a practice that introduces the possibility of recontamination from either the operator or the atmosphere.

It is desirable to sterilize X-ray film that is to be used on a patient during surgical procedures. This can not be accomplished by either heat or chemical solutions without damage to the material. "Immersion sterilization," as frequently practised in hospital operating rooms, has been proven completely inadequate. Its use should be limited to alcoholic formalin solutions followed by a sterile water rinse. Even this mixture is not completely satisfactory in that penetration into crevices and dried organic deposits may not be accomplished by the liquid.

Hospital bedding as a source of infectious agents has received a great deal of attention in its relationship to the infection rate in the hospital. Studies by Schwabacher *et al*,[1] in England have contraindicated the use of woollen blankets due to their tendency to harbor and shed staphylococcus. Dry cleaning procedures do not sterilize these blankets and are costly.

Upon visiting one hospital with a serious problem of staphylococcal infection, our laboratory learned that the highest staphylococcus count was in the hose to the anesthetic mask. How does one sterilize the anesthetic apparatus and retain the conductive nature of the rubber?

These are just a few of the areas in which sterilization problems may occur. There are undoubtedly many others. The purpose here is to discuss the development of a procedure that nicely fills much of the void in sterilizing methods. It is *not* a substitute for steam sterilization. In most cases where steam can be used, it should be used. This new procedure might be considered a sophisticated form of chemical sterilization. It avoids some of the pitfalls of solutions and offers many advantages.

A New Method

Ethylene oxide gas has long been used as a fumigant in industry. Its antibacterial activity was reported first in 1936. This discovery went essentially unnoticed except in the spice industry until studies by Phillips and Kaye[2] redisclosed its unique antibacterial properties. In their search for an agent useful in defence against biological warfare, these scientists found ethylene oxide gas to be active at ordinary temperatures and humidities. It is highly penetrating, leaves no residue, possesses relatively low toxicity, and can be easily handled in mixtures with inert gases that serve to decrease its flammability. Phillips and Kaye indicated that sterilization times of 6 hours at 70°F could be obtained with ethylene oxide concentrations of about 500 mg./l and with the relative humidity of the atmosphere between 20 and 40 per cent. The rate of kill of bacterial spores was shown to be dependent on the concentration of ethylene oxide, on temperature, and on the relative humidity of the system.

The Action of Ethylene Oxide

The reactions responsible for the sterilizing action of ethylene oxide

are, in general, reactions with groups common to all proteins or nucleoproteins. Amino or sulfhydryl groups appear to provide the major sites of reaction. As a result, the gas is active against all forms of microorganisms yet tested. Whereas, with most chemical disinfectants, bacterial spores are hundreds to thousands of times more resistant than vegetative cells, such is not the case with ethylene oxide. Spores of *Bacillus subtilis,* for example, are only five times more resistant to ethylene oxide gas than *Staphylococcus aureus.*[3] Friedl *et al,*[1] of the U.S. Department of Agriculture, reported that, of a series of 10 spore-forming organisms including the causative agents of anthrax, gas gangrene, and tetanus, *Bacillus subtilis* and *Clostridium sporogenes* were by far the most resistant to ethylene oxide. The resistance of a species may vary greatly from one strain to the next. In our laboratory we find *B. subtilis* about twice as resistant as our strain of *Cl. sporogenes.*

Almost all of the published data concern the sterilizing action of ethylene oxide at room temperature. Very little specific information is available in the literature with regard to its activity at elevated temperatures, in spite of the fact that commercially produced equipment operates at 130°F. It was for this reason that we embarked on a program to determine more accurately the relationship between temperature, gas concentration, relative humidity and time for sterilization.

Figure 1 shows killing time curves for populations of 2.7 x 10^6 spores of *Bacillus globigii* in two concentrations of ethylene oxide. It will be noticed that these data confirm the work of Phillips and Kaye with regard to the concentration dependence at low temperatures. As the temperature increases, however, the dependence on concentration diminishes until a critical temperature is reached for a particular concentration. At this point any increase in concentration has no effect on the rate of kill of bacterial spores. Thus ethylene oxide concentrations of 440 mg./l provide a slower sterilizing action than concentrations of 880 mg./l only at temperatures below 110°F.

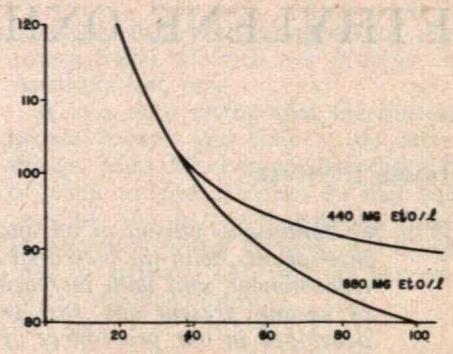

Fig. 1. *Effects of concentration and temperature*

Above this point there is no difference in the rates of sporicidal action of the two concentrations.

The influence of temperature on the sterilizing action of ethylene oxide is quite drastic between room temperature and 110°F. Above the range of 100°-110°F, however, less gain in rate of kill is evident and the practical value of higher sterilizing temperatures is questionable. In any case, a reasonable sterilizing time is obtained at temperatures above 100°F. The spores previously mentioned are destroyed in less than 40 minutes.

The relative humidity (RH) of the atmosphere plays an important role in the action of ethylene oxide. The rate of kill of microorganisms diminishes severely as the relative humidity drops below 20 per cent. Although there is some decrease in rate of kill as the relative humidity increases to 100 per cent, the added time is not significant in relation to the total time of the cycle. Therefore, it is considered ideal to establish a relatively high humidity as long as materials are not wetted in the process.

The Equipment

In order to apply the above data intelligently to practical procedures, we must know the internal behavior of the sterilizing chamber.

The apparatus used for ethylene oxide sterilization is usually a double-walled pressure vessel very similar to steam autoclaves. It is commonly heated by steam pulsed into the jacket in small quantities.

Figure 2 represents a typical sterilization cycle as depicted by variations in pressure and vacuum. An initial vacuum is drawn to remove the air from the sterilizer. This allows us to operate the sterilizer in reasonable pressure ranges, to dispense moisture readily, and to obtain rapid penetration of the gas into materials. The extent of this evacuation is usually 25″ of mercury below atmospheric pressure.

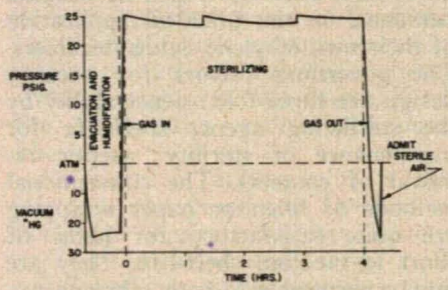

Fig. 2. *Sterilization cycle*

Since in the process of removing air we also remove water vapor, water must be added to the chamber to raise the relative humidity to an acceptable level. Steam is pulsed into the chamber until the relative humidity of the atmosphere reaches the desired level. It is important that the bacterial surfaces be in equilibrium with the moisture of the atmosphere, and that the moisture be allowed to penetrate to the internal portions of the load. For this reason, an amount of time is allowed to elapse prior to admission of the sterilizing gas.

Ethylene oxide is available commercially in mixtures with CO_2 or freons in the liquid form under pressure. Sudden release of this liquid mixture into a vacuum causes rapid expansion and drastic cooling. So that the gas can be placed into the vessel at reasonable temperatures, a small heat exchanger is built into the input line to volatilize the liquid and heat the resultant gas. The pressure of the gas in the vessel is increased to a predetermined operating pressure at which point the timing mechanism is started. The pressure is maintained throughout the timing cycle, usually four hours for hospital loads.

During the sterilization period, ethylene oxide dissolves in absorptive materials such as plastics, rubber and fabrics. Because large quantities of ethylene oxide in materials applied to tissue areas may cause severe chemical burns, it is important that the gas should be removed from these items. The rate at which ethylene oxide escapes from materials is accelerated by drawing a vacuum at the end of the sterilizing cycle and admitting sterile air to return the chamber to atmospheric pressure. About three-fourths of the dissolved gas is removed by this procedure. The remainder escapes quite readily upon aeration at room temperature.

Of primary importance in gaseous sterilization is the rate at which materials can be heated to a reasonable temperature (ca. 100°F.) for the action of ethylene oxide. Variations in methods of loading significantly influence the heat-up time of the load. They may cause it to vary from 30 minutes to 2 hours with a jacket temperature of 130°F (see Fig. 3). This slow heating is the main reason for the long cycle for ethylene oxide sterilization. The four-hour cycle allows two hours for heating the load, one hour for sterilization at a reasonable temperature and a one-hour safety factor. In many instances this time could be shortened but never without careful bacteriological control.

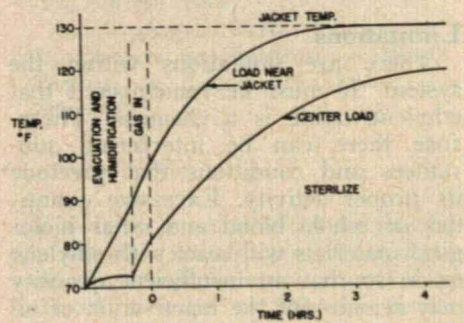

Fig. 3. *Temperature rise in an ethylene oxide sterilizer*

Probably the most critical part of the ethylene oxide cycle is the equilibration of the materials with moisture. Proper humidification of the materials is essential to sterilization. For this reason the steam is added while the system is under vacuum to allow the

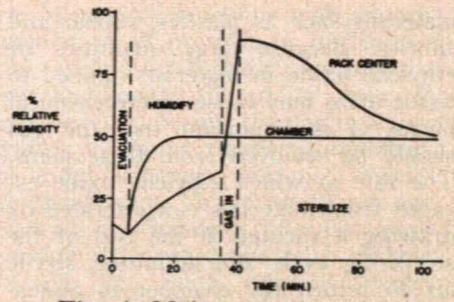

Fig. 4. *Moisture penetration characteristics with prehumidification*

moisture to penetrate without the interference of air. In most cases materials will be thoroughly humidified after holding the vacuum for 15-30 minutes. In extreme cases, where particularly dry materials are present, even this application may not provide complete penetration by the water vapor. Under such circumstances the incoming gas tends to drive the water vapor ahead of it into the central portions of the packages thereby completing the humidification process. Figure 4 shows the response of a humidity sensing element placed in the central portions of a very dry package. It will be noted that relative humidity rises slowly until the admission of gas into the chamber, at which time there is an abrupt rise in relative humidity in the centre of the package followed by a gradual drop toward the pre-set humidity level.

Limitations

There are limitations within the system. It must be remembered that ethylene oxide is a chemical. Therefore there can be interfering substances and conditions that preclude its proper activity. Excessive quantities of whole blood and other biological materials will react with ethylene oxide so that an insufficient quantity may remain for the inactivation of all microorganisms. Dried materials may fail to humidify properly in the ethylene oxide sterilizer. It is important that materials should be clean prior to subjecting them to ethylene oxide sterilization.

Ethylene oxide in water solution will damage certain rubber and plastic materials rapidly, while a gaseous mixture of water vapor and ethylene oxide gas will not. For this reason anesthetic masks, catheters and the like should not be moistened prior to ethylene oxide sterilization as is the practice with steam sterilization of rubber goods.

Preparation of Material

Packaging techniques vary from the traditional methods employed in steam sterilization to the use of heat-sealed plastic packages. Most of the procedures have been developed by hospital personnel in the practical application of their own ethylene oxide sterilizers. The governing factors for package design are three-fold: penetrability by the sterilizing agent; shelf-life for maintenance of sterility; aseptic removal of contents. The conventional methods of linen or paper wrapping are quite satisfactory for items of short to medium shelf-life. They are highly permeable to both ethylene oxide and water vapor. They can be opened conveniently so as to maintain asepsis. Where long or indefinite shelf-life is desired, plastics such as polyethylene, polypropylene, polyvinyl chloride or autoclavable nylon films are preferred because of their complete impermeability to microorganisms and their high rate of ethylene oxide transmission. They can be used as wrappings or as bags; either heat sealed or folded, as the only wrapping or as an outer wrap to provide long shelf-life. Not all plastic films can be penetrated readily by ethylene oxide. Sealed cellophane, mylar, acetate and butyl plastics should not be used.

Location of Equipment

The question often arises, "Where should an ethylene oxide sterilizer be located in the hospital." The answer depends primarily upon the hospital involved and the materials to be processed. The applications of ethylene oxide are so diversified that O.R., C.S.R., and housekeeping departments all have interests in its use. Operating room personnel may not prefer to let expensive lensed instruments out of their immediate supervision. C.S.R. supervisors generally prefer not to handle large quantities of bedding in Central Supply. The laundry seldom has personnel qualified to handle or supervise sterilization procedures. The

resolution of these difficulties lies with the administration.

Two examples show what can be done. At St. Mary's Hospital, St. Louis, Mo. one mattress-size sterilizer satisfies all of their ethylene oxide needs. It is located in the basement near Central Supply and is under the supervision of the laundry. All mattresses, pillows and blankets in the hospital are sterilized in this unit. In addition, a vast array of materials from the entire hospital is sterilized. These items include isolettes, lensed instruments, suction apparatus, patient's clothing, surgical rubber gloves, X-ray film, bone saws, radios and many others.

An alternate arrangement is that found in the Northside Division of Rochester General Hospital, Rochester, N.Y. In this instance, a 16" x 16" x 30" sterilizer in the operating room suite provides sufficient capacity for O.R. needs such as cystoscopes, Esmarch bandages, dermatone blades and so forth. A 24" x 36" x 60" chamber in Central Supply is used for bedding, rubber gloves, nipples from the nursery and other items. In both hospitals there are certain noteworthy factors. In the first place, there is proper administration of traffic, and in the second, competent personnel organize and supervise the sterilization procedure.

Summary

1. The action of ethylene oxide is primarily temperature dependent. The concentration is less critical at the temperatures normally employed. Relative humidity and consequently, moisture content of materials is also important.

2. Materials must be clean and packaged so as to permit adequate penetration by ethylene oxide.

3. Although automatic ethylene oxide equipment has been available for only five years, many institutions already find it an invaluable tool to perform tasks for which there had been no really adequate procedure. It permits more freedom in the development and use of new materials and advanced techniques by providing a means of sterilization. Heart-lung machines, eye and ear instruments, microscopes, and artificial kidneys are just a few examples of instruments for which ethylene oxide is almost essential.

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2. Phillips, C. R.; Kaye, S.: The sterilizing action of gaseous ethylene oxide. *I. Review Amer. Jour. Hyg.*, 50:270. 1949.

3. Phillips, C. R.: The sterilizing action of gaseous ethylene oxide. II. Sterilization of contaminated objects with ethylene oxide and related compounds: time, concentration and temperature relationships. *Amer. Jour. Hyg.*, 50:280. 1949.

4. Schwabacher, Herta; Salsbury, A. J.: Blankets and Infection — Wool, Terylene, or Cotton? *The Lancet*, p. 709. 1958.

The Canadian Pharmaceutical Manufacturers Association has established a Speaker's Service which will provide top-level speakers for business organizations and associations, service clubs, consumer associations and allied groups.

The purpose of this service is to carry the story of pharmacy to groups across the country. The speakers have been selected from within industry and the service is free to all adults' clubs, with no fee charged for either the speaker's time nor for travelling expenses.

The speakers will address interested groups on the pharmaceutical industry, the cost of drugs, the story behind the prescription and other related topics. Those organizations interested in having a speaker are requested to write to Speaker's Service, Canadian Pharmaceutical Manufacturers Association, 37 King Street East, Toronto 1, Ont.

* * *

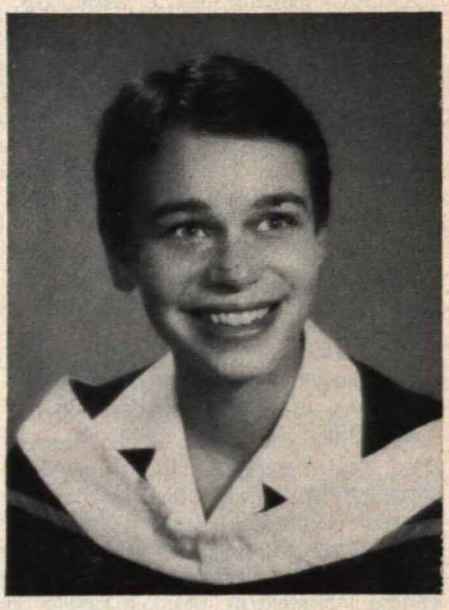
Frequent among adults, headaches have a different significance among children. When a child is upset, worried or disappointed, he usually has a stomach reaction and vomits. His headaches are almost always caused by the fact that he needs glasses.

World Health, March-April 1962

NURSING PROFILES

Virginia Ann Lindabury has joined the staff of the *Journal* as an English assistant editor. A graduate of the Toronto General Hospital in 1953, she obtained her diploma in nursing education from the University of Western Ontario in 1955 and completed requirements for her B.Sc. in Nursing at the same university in 1959.

For the past three years Miss Lindabury was the assistant director of nursing education at the Brockville General Hospital. Previous experience included two years as surgical instructor at the Wellesley Division, T.G.H. and a year at the Royal Victoria Hospital, Barrie, Ont. as medical-surgical and pediatric instructor. In addition, she has done private nursing at various times in Toronto and London, Ont. and general staff nursing in the San Joaquin General Hospital, Stockton, California for about six months.



VIRGINIA LINDABURY

Also taking up full-time duties with the *Journal* is **Claire Bigué,** French assistant editor, who has been completing requirements for her degree in nursing from Institut Marguerite d'Youville, Montreal.

Quebec born — Amos is her home-town — Miss Bigué studied at Ecole normale de Nicolet, P.Q. and at the University of Ottawa before beginning her nurse's training at the Ottawa General Hospital. She had

(Jac-Guy, Montreal)

CLAIRE BIGUÉ

several years of experience in operating room work in a hospital in Noranda and in the O.G.H. in general staff and supervisory positions.

In addition to assisting with the preparation of regular issues of the French edition, *L'Infirmière Canadienne,* Miss Bigué will

(Le Roy Toll, Toronto)

CAROL HUTTON

spend a large proportion of her time securing original articles in the French language; explaining the use of the *Journal* as a teaching aid; helping and encouraging French-speaking nurses to prepare material for publication.

The *Journal* extends a very warm welcome to these new staff members. Their help will be much appreciated in coping with the increasing work load of this office. They in turn, are looking forward to a closer association with you, the readers, as they carry out their various responsibilities.

Carol Jean Hutton, an inspector of provincial schools of nursing with the Ontario Department of Health, was born and educated in Saskatchewan. After her graduation from the Calgary General Hospital in 1951, she travelled north to Anchorage, Alaska where she engaged in obstetrical nursing for a year before returning to her native province as night supervisor at the Swift Current Union Hospital.

In 1953 Miss Hutton enrolled in the public health course, Queen's University, Kingston and obtained her diploma in this specialty. Later, study at the University of Toronto, 1958-60, won for her the degree of B.Sc.N. As a public health nurse, she served with the Sudbury branch, Victorian Order of Nurses and as supervisor of public health nursing with the Stormont, Dundas and Glengarry Health Unit, Cornwall. In addition Miss Hutton has had several years of experience as an occupational health nurse.

An enthusiastic sportswoman, she enjoys a wide variety of activities that include golfing and curling. Other interests are music, reading and the theatre.

In Memoriam

Edith Maria Barker (Wyneworth Union Hospital, North Shields, Northumberland, England '14) died on April 14, 1962 in Vancouver. She was a former matron of Maywood Hospital, Vancouver and for a period of 17 years she was matron of the Loyal Orange Protestant Home for Children, Indian Head, Sask. Miss Barker served with Queen Alexandra's Imperial Military Nursing Service 1916-19.

* * *

Marguerite Bellhouse (Royal Victoria Hospital, Montreal '16) died on April 15, 1962 in Kingston, Ont.

* * *

Florence (Wood) Clarke (Brandon General Hospital, Man. '23) died February 18, 1962 in Oakland, California after a brief illness.

* * *

The Alumnae Association of the Vancouver General Hospital pays tribute to the memory of the following graduates: **Meta Adele (Perry) Cunningham** '15; **Alice (Sheppard) Gallagher** '09; **Constance Susan (Milne) Gordon** '19; **Annie Mary (Esselmont) McKay** '17.

* * *

The Alumnae Association of St. Boniface Hospital, Man. pays tribute to the memory of **Josephine (Parenteau) Fontana** '03; **Elizabeth (McRae) Lyon** '03; **Ethel Miriam (Oliver) Tweltridge** '13.

* * *

Margaret R. Hayes (St. Joseph's Hospital, North Bay '41) died in Ottawa on March 25, 1962. She was employed as an industrial nurse with the Hayes Steel Products Limited, Welland, Ont. before joining the staff of the Civil Service Health Division, Ottawa in 1953 as a nursing counsellor.

* * *

Gladys Elizabeth McBroom (Kingston General Hospital, Ont. '27) died in Toronto on March 23, 1962. She was engaged in institutional nursing.

* * *

Janet Munroe McClung (Winnipeg General Hospital '12) died in Vancouver on March 23, 1962. She had served in England and Malta during World War I as a nursing sister. Miss McClung was 78 years of age.

* * *

Emily (Fearon) McInerney (Victoria Public Hospital, Fredericton, N.B. '37) died in Cambridge, N.Y.

* * *

Lula M. (Blair) McLandress (Ontario Hospital, New Toronto '39) died in Ancaster, Ont. on March 30, 1962.

* * *

The Alumnae Association of the Montreal

(*Continued on page* 628)

THE WORLD OF NURSING

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA

Canadian Nurses' Association Retirement Plan

The CNA Retirement Plan was designed especially for nurses. It is actually two plans in one:

A Personal Plan (Plan A)

Plan A was designed for nurses in private practice and for nurses who wish to supplement their retirement benefits.

An Employer-Employee Plan (Plan B)

Plan B was designed for nurses in regular employment. It is available to all employers of nurses for *all* employees.

Both Plans A and B may be transferable.

Both Plans have two funds:

The Guaranteed Annuity Fund with the National Life Assurance Co. This provides the nurse with a guaranteed pension at retirement, and

The Common Stock Fund with the Royal Trust Co. The Unit value in the Common Stock Fund fluctuates with the rise and fall of investment values and provides the nurse with protection against inflation as generally speaking the market value of stocks keeps pace with the cost of living. This provides the nurse with an opportunity for safe investment.

HISTORY OF PLAN A

Yearly Interest Rate

February 1959	—	4.50%
February 1960	—	4.50%
February 1961	—	5.13%
February 1962	—	5.25%

Yearly Unit Value

1 March 1959	—	$10.00
1 March 1960	—	$ 9.26
1 March 1961	—	$10.92
1 March 1962	—	$12.56

Occupational Health Nursing

The University of Toronto has undertaken a research study concerned with the field of occupational health nursing. The first phase of the study is planned to gain more precise knowledge about the functions and activities of the nurses working in industry and those providing health services in hospitals, municipal governments, and other non-industrial situations. The second phase will be concerned with the education of the nurse for these functions.

This study is to be conducted by the Department of Physiological Hygiene, School of Hygiene, in collaboration with the School of Nursing, University of Toronto. It is financed by a health grant from the Department of National Health and Welfare. Dr. J. R. BROWN, M.B., Ph.D., Professor and Head of the Department of Physiological Hygiene, is director of the study, and Mrs. J. EVLYN DALMAN is the investigator.

Additional information may be obtained from Mrs. Dalman, Department of Physiological Hygiene, School of Hygiene, 150 College Street, Toronto 5, Ontario, Canada.

ICN Staff Changes

Miss ELLEN BROE, Director of the Florence Nightingale Education Division, ICN, is resigning from her position in August and will return to her home country, Denmark, after ten years in London, first as Director of the Florence Nightingale International Foundation and subsequently with the ICN.

Miss INGRID HAMELIN, who joined

the ICN staff as assistant director in the Education Division last August, will succeed Miss Broe as Director of the Division next September.

ICN Competition

The International Council of Nurses, through its Ethics of Nursing Committee announces an International competition which is designed to reach individual nurses to increase their awareness of the meaning and significance of nursing ethics and to bring to their notice the ICN Code of Nursing Ethics.

The subject of the Competition is "A Pledge for use in Graduation Ceremonies in Schools of Nursing" based on the International Code of Nursing Ethics.

Conditions of Entry

1. The competition is open to all Graduate nurses who are members of ICN Member Associations. If any question arises as to the eligibility of a contributor, the decision of the panel of judges shall be final.

2. The Pledge shall be typewritten on one side of the paper.

3. Each entry must be signed by a *Pen-name*. The name and address of the contributor must be enclosed in a sealed envelope, on which the pen-name is given, and attached to the manuscript.

4. The entry must be forwarded by the National Nurses' Association of the country concerned by the 31st December, 1962. The closing date for National Entries will be decided by the country concerned.

5. A Prize will be awarded for the winning entry which will be published in the *International Nursing Review*. No entry may be sent which has previously appeared in print.

6. No entry submitted may be published in any Nursing Journal or in any other form without the permission of the International Council of Nurses.

7. Entries will be returned to the writers after the results of the competition have been announced. For this purpose a self-addressed envelope should be enclosed with the original material, and the cost of postage refunded. Do not put a stamp on the return envelope.

CNA School Improvement Program

The CNA School Improvement Program Task Committee met in June. The purpose of this meeting was:

1. To review the completed Questionnaires and Self-Evaluation Guides for the purpose of determining the areas of the educational program where the participating schools require assistance;

2. to suggest means for implementing a follow-up program which will be in line with the direction given previously by the Executive Committee;

3. to review the Canadian Nurses' Association School Improvement Program and suggest plans for the future.

CNA Publications

Nurses across Canada will be pleased to learn that *The First Fifty Years — A Record of CNA History*, has been revised and is now available in both English and French at cost price under the title *Fifty Years and More*.

Facts and Figures about Nursing in Canada has been revised and is available in English at cost price. This booklet now appears under the title *Nurses and Nursing in Canada*.

The new publication *Continuing Care, The Nurse and Community Resources* is now available in English and French at cost price.

The following newly revised copies of publications are available in English and French, free of charge:

The Fishing Nurse, an informative booklet on the Canadian Nurses' Association Retirement Plan.
CNA is Your Association
ABC of CNA
ABC of ICN

CNA Catalogue of Publications, prepared by the CNA Sub-Committee on Public Relations, will soon be available in French and English to replace the former CNA Publications List.

One should oblige everyone to the extent of one's ability. One often needs someone smaller than oneself. — DE LA FONTAINE

More than two million Canadians volunteer their time and effort to serve in some voluntary capacity for Red Cross.

PHILOSOPHY OF GERIATRIC CARE

J. R. D. BAYNE, M.D.

Are old people a burden to themselves and others?

THE GENERAL PUBLIC hears more and more about the rapidly increasing numbers of old people in our society, and of the apparent "burden of dependency" these supposedly helpless and useless members threaten to become. As the medical and nursing professions are considered partly responsible for this occurrence, and as we are expected to provide medical and nursing services as may be required, we should have our thinking clear on this subject.

It is true that the numbers of people over 60 years of age are increasing in all so-called "advanced" countries of the world. This is chiefly due to control of diseases of childhood in the last century and, also, control of maternal mortality, so that there were more survivors. These are the elderly of today. Medicine has been much less successful in prolonging the lives of the old people themselves. However, this too will probably become more possible in the future.

Is this a matter of prolonging useless lives? We are being told repeatedly in the lay press that people should be allowed to die "when they are old" or "when their time has come." Can we recognize such a time and should we then withold treatment? We have noted that more people are living to be old today than did in the past, but there were always a few very old survivors even in ancient days. We have no documental evidence of an individual human living beyond 110 years.

It seems then that even the toughest survivors eventually reach the end of their program. Autopsy examination of the bodies of very elderly people often fail to show a clear cause of death. Many organs may show degenerative changes but none perhaps will show such advanced disease as might be considered the definite cause of death. The younger the person at the time of death the more likely one is to find a clear-cut cause and a distinctively diseased organ. This suggests that death before the age of 90 to 110 may be due to disease, preventable or curable.

Diseases appearing between the ages 60-90 are often said to be "due to aging." This is true in the sense that they take a long time to develop and they would not commonly occur at an early age. However, they *are* diseases and therefore they are probably preventable. Certainly one must not think that they are inevitable. It must be realized that "diseases of childhood" such as measles or mumps may occur in old age, and some diseases of old age such as coronary atheroma and stroke may occur in childhood. If we could prevent or cure the diseases of old age we could prevent much disability and suffering.

It should be noted that not all elderly people are disabled. Although many may have one or more chronic diseases such as arthritis, diabetes, angina or chronic bronchitis, less than 5 per cent of them need to be in any institution in any country. A large number lead active lives in business, the professions or politics. The people who are disabled are those who are afflicted by serious acute or chronic disease. It is obvious that they need treatment and they usually get it. However, because of the expense of long-term care and because of our impatience, we sometimes terminate active treatment too soon. Recovery from disablement goes on at different speeds in different people. It depends largely on the motivation of the person affected. If doctors and nurses regard old age itself as a disability and are unwilling to give the necessary time to his care then the patient may never recover.

Our professional duty as doctors and nurses is to alleviate suffering and to treat or prevent disease. When we label certain diseases as hopeless, we may tend to ignore or lose interest in the person with the illness. Treat-

ment need not go to extreme lengths but everything should be done that will relieve pain and prevent further disability. Treatment should not be given just to make us feel secure that all the conventional things have been done. Treatment should be given as it is really indicated. Little things can often be found to help the very ill patient. Even the severely disabled person may derive pleasure and pride from helping himself a little. Encouragement and emotional support can be given by a nurse or attendant who is not afraid to help a patient to face death.

Several things make it difficult for us to treat the elderly and the disabled. We may see ourselves in their place and become depressed or frightened. We may be asked by the patient to help him face emotional problems that are disturbing to us because we have not got them settled in our own minds. An elderly person may seem like a parent to us. We may feel overawed by him, or angry because we are angry with our own parents. We may even be cruel without realizing we are "getting even" for some supposedly unfair advantage one of our parents may have seemed to have had over us as children. As doctors and nurses, we may think of ourselves as very important people, able to save lives, dedicated to an ideal that puts us above others. We may be upset if an old person speaks to us as to a child, or if a favorite patient, in spite of all we can do, just goes on to death.

Nursing sick old people brings out all of these problems. It may be that to enter this field of nursing care requires a special sense of dedication and a certain type of personality. However, all nurses must face these problems in some degree, and should comprehend the challenge of the work and its value.

In the Good Old Days

(*The Canadian Nurse* — JULY, 1922)

Measles was responsible for 44 per cent of all deaths in children between the ages of one and two years of age. Most of these deaths were due to bronchopneumonia which would not have occurred if measles had not first prepared the way. Scientists are now endeavoring to reduce the virulence of the measles virus in order to produce a very mild type of disease which will not create the danger of pneumonia but which will confer lasting immunity.

* * *

Nurses have fought for their "R.N." on many a legislative battlefield. It has come to be a symbol of a profession; the magic two letters that open the door, that place the seal of qualification and proclaim the holder as one who has met fairly stiff requirements. Why do we find it absent so often when officially it belongs at the end of a name? Mary Smith is just a woman; but Mary Smith, R.N. is a registered nurse who has standing and status.

* * *

Today, the school health staff are very important agents in the correlation of good health and pedagogy, in order to produce the maximum of mental and physical efficiency with the minimum of wasted effort. School medical inspection has justified its existence and warrants a place, not as an auxiliary, but as an integral part of the academic program in any community.

* * *

Rural nursing is far more satisfying than working in a city, even though the hours are longer and the hardships greater. It may not be quite as remunerative but there is more chance to prove the true principles of nursing — charity and service.

Wild animals never kill for sport. Man is the only one to whom the torture and death of his fellow-creatures is amusing in itself. — JAMES A. FROUDE

I maintain that ideas are events. It is more difficult to make them interesting I know, but if you fail the style is at fault. — GUSTAVE FLAUBERT

AGING – A Project Report

"Old age" is a relative term. It has little to do with the number of years a person has lived. Some are old at 40. Others are still vigorous, interested and happy after 90. In the discussions that follow, chronological age yields place to physiological and psychological age.

THE PROCESS OF AGING

ALL LIVING THINGS must grow old and human beings are no exception to the rule. The process of aging creates new problems that require scientific study and research. Certain signs indicate that normal aging is taking place in the individual. The age at which these physiological changes appear may vary widely.

With age there is general tissue desiccation and slowing of cell division. This means that healing will take place more slowly and that the body response to infection will be less rapid and perhaps less effective. There is gradual loss of the elasticity of connective tissue. This leads to decreased speed of response and diminished strength as well as increased rigidity of body structures. Bones become brittle and rarified. Falls, from which young people may suffer only a few bruises may cost many older people weeks of hospital care and bed rest. In later years, there is a fatty infiltration of cells and lessened elasticity of blood vessels. There is a proneness to dizziness and syncope that may result in unavoidable accidents. As blood vessels become hardened and less elastic, circulation becomes less efficient, especially in the lower limbs. Varicosities, even thrombi may occur. Greater sensitivity to temperature changes result from the slowed-down circulation.

The robust, healthy skin becomes thin, delicate and sensitive to trauma and pressure. Tiny arterioles near the skin surface atrophy and harden, causing the skin to lose its rosy bloom of youth and become sallow. The loss of subcutaneous tissue produces wrinkles and sagging of the skin. Sweat glands atrophy and the excretory function of the skin lessens.

The older person finds that his fingernails and toenails may become hard and dry and the skin of his feet dry and flaky. The hair, once a shining, lustrous "crown," may become thin, dry and colorless as the tissues age and the blood vessels diminish in activity. The distribution and quality of hair changes with age. In the axillary and pubic areas it becomes finer and scanty while the eyebrows become coarse and bristly. Stray hairs on the face of elderly women, especially on the chin, are not uncommon.

As age increases, sight tends to fade and glasses may be needed. Although many senses diminish, the sense of touch is retained and the older person often enjoys working with her hands. But it must be remembered that old hands and eyes tire easily.

Free hydrochloric acid in the stomach may be decreased which predisposes to impaired digestion and poor oral health. Gum tissues become less elastic and less vascular and the gums may recede from the teeth, exposing areas that are not covered with enamel. Such areas are sensitive to injury from brushes and coarse dentifrices. Decayed or broken teeth result in avoidance of foods that are difficult to eat but which may be necessary for good health, while improper chewing produces indigestion.

As aging progresses muscle tone becomes less adequate and slumped posture may result. The person seems to shrink and may become very fragile in appearance. Lessened elasticity of tissues tends to make these changes fixed. There is gradual slowing down in all movements. The very old may sleep for only short periods at night then doze during the day. Actually, this meets the normal requirement for sleep.

Overweight may be a problem in youth but after 40 every extra pound puts an unnecessary burden on the heart and circulatory system.

Aging may bring cerebral deterioration with resultant senility, forget-

fulness and sudden childish impulses. Regular medical check-ups continue to be necessary. They help to detect illness early and to prevent or delay disabilities.

The boundless energy of youth is often wasted but energy, like money, must be more wisely used when there is less of it.

PROPHYLAXIS

People do not suddenly change once they have lived a certain number of years. They need to love and be loved; to secure companionship, recognition and personal achievement in order to maintain a sense of personal worth. They need somewhere to live, something to do, and someone to care. Economic security with emotional insecurity cannot give anyone happiness. Young people, in their attempt to provide for their older relatives, often rob them of their independence by over-protection and by not letting them do what they are still capable of and which would make them feel needed and useful. Every individual should feel that there is at least one person in the world to whom he is extremely important. We all need companionship. Mere physical existence is not enough; life must have meaning and purpose.

The aged must have a feeling of security and independence. Unhappily, many of them exist on marginal pensions. Without some goal in life, many older people may lose their will to live because of loneliness and idleness. Many such tragic declines could be prevented by providing the means to fulfill two basic human needs: a pleasant place to live; something worthwhile to do. Low-cost apartments or housing would ensure greater self-respect and self-sufficiency. Many of the aged now in hospitals could fend for themselves in special housing communities. They might need the added help of a kind already available in some communities: V.O.N. services, housekeepers, or delivery of one hot meal a day.

Though there is a widely accepted feeling that the older worker is both slow and inefficient, experience has demonstrated the inaccuracy of this belief. These people are eager for work and sick of idleness. To be useful is a basic human need at any age. Retirement from their life's work has created leisure time for many thousands of people which they soon find tedious. This problem has been tackled in various ways. Many employers hire older people and are usually very well satisfied with the quality of work turned out. Some older people find a useful place with their families. Others give generously of their time to church work and charitable organizations. However, there is still much concern for those who must spend their declining years in idleness and lonely frustration.

Good hygiene and good nutrition are important in keeping people healthy at any age. Many people who live alone just cannot be bothered preparing proper meals. Sometimes, if the income is low, they cannot afford the proper foods. They must be helped to realize how important a good nutritional state is for happy, healthy living. With the help of a public health nurse or some other qualified person, a reasonably inexpensive and adequate diet could be worked out.

Despite the encouraging demonstration of enduring happiness and vigor offered by some of the elderly, most of us feel that youth is everything and old age is a disaster! We young women tend to pity old people! We often try to avoid them. Sometimes we even laugh at them. Aging is a prospect that everyone faces. Some of the ways in which it can be met most successfully are:

Do not fear the ills and infirmities of age;

change our ideas about aging;

modify the compulsory retirement practices;

improve housing facilities;

provide new kinds of jobs and services.

SPECIAL PROBLEMS

People continue to vary in nature regardless of age. Age, basically, does not change a person's temperament or character. If, in youth, he was exacting and selfish, or generous and considerate these same qualities will still be found in later life. However, the aging process may introduce other differences. While some aged persons

remain mentally alert and physically independent, others may become completely dependent. Then there is a large in-between group who require only some assistance or supervision to maintain their independence.

Many older people find it difficult to verbalize their concerns and problems although their needs are really no different from those of any other person. However, they may be faced with adjustments that make it difficult and even impossible for these needs to be met.

One of the greatest problems seems to be heartbreaking loneliness. Many of their contemporaries are dead, have moved away or are unable to get about. This situation, plus the loss of a spouse whose companionship has developed over many years, often leaves the elderly man or woman without an incentive to live.

Independence may be lost and financial insecurity added, as the older person moves in with relatives. It becomes a trying situation for the family, especially if the aged member is bedridden or chronically ill. Varied emotional reactions are bound to occur. The aged person lacks the flexibility of youth and finds adjustment to the frustrations of limited activity exceedingly trying. The family may have to adjust to the care of a bedfast individual or perhaps one who is mentally incompetent.

Motivation is an exceedingly important need. There must be a goal in life in order to prevent purposeless drifting; to direct activity. Motivated activity brings about happy, independent living; keeps the spirit lively and keen by counteracting frustration, insecurity and a feeling of rejection. Without motivation people are apt to fall into a state of apathetic listlessness. In the case of the aged they may tend to spend day after day ensconsed in an easy chair, dreaming of long forgotten days. In the words of Eleanor Roosevelt

> The ability to relax, recuperate and enjoy is, I suppose, partly an attitude of mind. Like most older people, I am constantly fighting the temptation to slip into self-absorption. If one loses interest in the people who tie one to life, then it is very easy to lose interest in the world as a whole. This, I think, is the beginning of death.

Growing older can mean growing into wisdom. *People are capable of growing mentally at any age, in fact they cannot stand still; they either grow or deteriorate.* There is no need to become out of touch with the affairs of family and of the world. The younger generations can add interest to the lives of their elders simply by being interested in them. They must learn to accept a loss of memory as they accept dentures or hearing aids. They must realize that older people do not wish to be pampered or patronized but they *do* want their desires taken into consideration.

Whatever may be the nurse's program of care for elderly patients, it is essential to let them take part in the planning; to allow them to make their own decisions according to their needs, their environment and their abilities. The nurse must respect their rights and avoid imposing her solutions, ideas and views upon them. The desire to be independent and self-reliant does not cease with advancing years. We should not expect people to accept changes and plans made for them without their concurrence.

A bill of rights for the elderly might include:

1. The right to be treated as persons, as individuals. They have no psychological need to conform, as does the adolescent.
2. The right to be treated as adults; to be allowed to exercise their own judgment. The right to think; to be listened to; not pushed around like helpless cripples.
3. The right to manage their own lives, or at least to have a say-so in any plans benevolent relatives may be designing for their care.
4. The right to companionship of their own choosing. Their environment should include some from every age group so that they can play and have fun.
5. The right to be useful, to have a sense of worthwhileness. They do not want to be a burden on their children. Too often concealed misery detracts from happiness when the aged live in the homes of their children.
6. The right to be old.
7. The right to call upon professional

help when necessary, to direct their capacities and learning abilities.

NUTRITIONAL ASPECTS

Good nutrition for all age groups depends upon the supply and utilization of the five nutritional factors: Protein, carbohydrates, vitamins, minerals and fats.

Uncle Dan is an example of an elderly person with poor eating habits. He had eaten well until the death of his wife, and then he lost his interest in food. For breakfast he ate what student nurses so often eat — only coffee and toast! His lunch consisted of peanut butter sandwiches and tea. Uncle Dan usually had a good appetite at supper due to his daily glass of beer. He managed to consume one greasy hamburger and a half order of "chips" at the corner lunch counter.

This diet is deficient in everything! Uncle Dan completely ignored the five nutritional factors. In these modern days, an adequate protein intake is the hardest thing to ensure for the aging person on a modest income because foods supplying it are so expensive. If he does not receive dietary protein, his body will utilize this only store at its disposal — his muscles — and he will waste away. When wasted muscles can no longer supply the necessary protein, the level of the blood protein will fall, leading to loss of resistance to injury and infection.

Minerals are needed to maintain strong bones that are resistant to fractures. Vitamins are essential to nervous stability and resistance to disease and also for the body to make the best use of the food it receives. It is important to control the intake of carbohydrates and fats since an excess of these is frequently the cause of obesity. When the elderly patient falls ill, obesity may hinder the success of treatment. Reduction of the total quantity of food, together with restriction of sugar and starches, is usually effective in weight control.

Causes of poor nutrition may be: Limited financial resources; psychological factors such as boredom and seeming uselessness; lack of sufficient knowledge of the essentials of a well-balanced diet; poor teeth.

The best example of a person with excellent eating habits is our friend John Smith. Although John is a bachelor, he has had good eating habits since childhood. He does all of his own cooking and manages to eat three well-balanced meals per day. They include one and one-half pints of milk; one egg and a serving of meat or fish; at least three pats of butter; two or three servings of enriched breads or cereals; a yellow or green leafy vegetable, and fruits high in vitamin C such as oranges, grapefruit and tomatoes.

Attention to good nutrition is important both in hospital and in the patient's home. The elderly patient sometimes becomes stubborn at mealtimes. The nurse must encourage him to eat and she must have patience. He will probably eat more slowly but he will eventually finish his meal. If she takes the trouble to find out his likes and dislikes it will help the nurse to decide what to feed him. She should always be sure that dentures are properly fitted into the patient's mouth. This will make his meal more enjoyable and the food will be chewed more thoroughly.

DISEASES OF THE AGED

The characteristics that distinguish the disorders of later years may be summarized as:

1. Multiplicity of causative factors.
2. Overlapping and superimposition of disorders.
3. Chronicity and progressiveness.

In youth, the causative factors in disease are usually external, specific and operative only shortly before signs of disease become evident. In the aged, on the other hand, the causation is usually internal and tends to be cumulative. The condition may have existed for a long period of time before its recognition. A further contrast is provided in that the onset of an acute disorder in youth is usually conspicuous, whereas in later years disorders appear insidiously and progress for a long period of time without symptoms.

General Principles

1. *The precarious balance of health:* With increased age health may become a very uncertain thing and even minor upsets may produce grave illness. With increasing years there tends to be dif-

ficulty in adjusting to changes in environment. Some elderly patients stand change badly:

> a fresh room, or a move to hospital, may precipitate an episode of confusion from which the patient may recover slowly as he familiarizes himself with his new surroundings.

This instability of health is due to the failing efficiency of the vital organs of the body, which can do their work only as long as no additional strain is placed upon them.

2. *Frequency of multiple pathology:* While in early and middle life we look for one disease process to explain the patient's various symptoms, in old age we may find more than one disease. The main reason for this is the gradual degeneration of the vital tissues of the body due to arteriosclerosis, a consistent bodily finding in old people of Western civilization.

3. *Importance of predisposing factors:* These are important because their removal and the prevention of their return may restore the patient's health to normal and keep it so. The presence of anemia is upsetting to the functions of the brain, heart and kidney. Obesity produces a state of strain in any body system. Latent infection is a further source of damage to the body.

4. *Influence of minor defects:* Minor defects in the eyes, ears and feet are of importance to the elderly person because of the effect on treatment of the major condition.

5. *The influence of mind over body:* The condition of the mind is a big factor in shaping the patient's complaints. In the absence of distressing bodily disease a contented elderly patient makes very few complaints. That the complaints are few in number may be due to the fact that pain is less acute in the aged. It may also be due to the fact that the older person suits his actions to his physical abilities. Even when he has no family to think of him as a person of significance, his nurses and attendants can give him the greatest satisfaction if they will take a kindly, understanding and sympathetic interest in him.

Gastrointestinal Conditions

Diseases of the gallbladder increase with age due to degenerative causes, poor dietary habits and, in some cases, stress agents.

Intestinal obstruction is more likely to occur as a result of less effective function of the intestinal musculature. The problem of constipation in the old, as in the young, is an individual problem. The resulting symptoms may depend largely upon the importance which the patient attaches to the question. Dietary changes contribute to constipation.

Carcinoma and gastritis are also common in the older age group.

Diseases of the Lungs

Chronic pulmonary emphysema, chronic bronchitis and pneumonia are seen more frequently in the aged.

The factors predisposing to chronic bronchitis are cold, fog and dampness. During winter, the cough becomes more persistent. Care should be taken to prevent the lung bases from becoming plugged with sputum and functionally impaired. If a patient tends to huddle in bed so that the lower part of his chest cannot expand properly, it may be best to have him sit upright in a tall armchair. Postural drainage encourages him to cough up sputum and clear his bronchial tubes as thoroughly as possible, preferably twice a day.

Pneumonia in the aged is a common and frequently fatal disease. If, as is predicted, a gradual advance in the average age of our population occurs, pneumonia will become an even more pressing medical problem. Bronchitis, emphysema and congestive heart failure predispose to pneumonia. The possibility of this condition must be kept in mind in the care of any elderly person who has had a major fracture or a surgical procedure entailing anesthesia or prolonged immobilization in bed. The symptoms may be classical or, on the other hand, they may be so insidious as to be overlooked. Frank chills, are less common. Cough may or may not be present and is sometimes overlooked if the patient has a chronic cough. The sputum is less rusty than in the case of younger persons, and may be absent because the patient swallows it. Pleuritic pain is comparatively uncommon.

Excessive tachycardia is of greater

significance than high fever, although the latter should be considered an ominous sign. Frequent checks on the various evidences of pulmonary edema are extremely important, since death in pneumonia is usually due to shock and consequent pulmonary edema.

Mental Disorders

Mental deterioration when it occurs is the most grievous infirmity of advancing age. Deterioration is seen in three fields: Physical, intellectual, and emotional.

Physical aspects include general weakness and loss of efficiency; gradual lack of acuteness of special senses; wrinkling of skin due to loss of subcutaneous fat; various bone deformities and the reduction of cardiovascular efficiency. Intellectual deterioration may be indicated by poor concentration and attention; impairment of memory, especially for recent events, and impairment of judgment. Emotional impairment may be evidenced by apathy or the patient may show a pathetic childishness.

Early diagnosis of psychosis is important for the protection of the patient and of his relatives. Unfortunately, medical advice often is not requested until late. Many such patients can be successfully managed in their homes for some time. When this is no longer feasible, they may be placed in a suitable institution. The problem of caring for the person with a mental deviation has been greatly complicated by the increasing urbanization of the population. While it would be perfectly acceptable to keep an elderly grandfather busy and happy doing minor jobs on a farm, even though he may be a bit confused, untidy about his dress and have a very poor memory, it is impracticable to maintain him in a small apartment in a city.

No medication will alter the eventual outcome of the condition. Sedatives are avoided whenever possible because of their tendency to cause confusion.

Heart Conditions

The incidence of heart disease is increasing. Part of this may be due to the aging of the general population plus an increase in total population. The three most prevalent causes of heart disease are hypertension, rheumatic fever and coronary artery disease.

Arteriosclerosis is estimated to affect 78 per cent of persons between ages 60-69 and 90 per cent of those 70 years and over. In arteriosclerosis, atherosclerosis is the greatest human killer. The disease begins with fatty deposits in the root arch and posterior wall of the aorta. Thrombosis is favored by injury to the vessel wall and by constriction due to intimal plaque formation. Contributing factors are mechanical ones which result from local vascular stress, with increased incidence in diabetes mellitus, myxedema, nephrosis and obesity. Hypernutrition, by producing elevated cholesterol is a definite factor, although the process takes years to unfold.

Hypertension refers to a sustained increase in blood pressure that may persist for years and often is very compatible with a long life. Older individuals may have a benign type of high blood pressure where the systolic blood pressure is elevated to varying degrees and the diastolic blood pressure remains below 90 mm. of mercury. This type is thought to be directly associated with arteriosclerosis. However, a benign hypertension may become malignant suddenly with rapid deterioration. Specific treatment is necessary in an effort to save the life of the patient.

In persons over 65 years, the major cause of heart mortality is disease of the myocardium. Heart failure may be acute and final or it may be chronic with acute exacerbations that constitute a medical emergency. Failure may be right-sided or left-sided depending on the area of the system affected. Right-sided heart failure results from failure of the damaged myocardium to prevent congestion in the pulmonary circuit. When this becomes more marked, stasis of circulation occurs in the liver and kidneys. This causes depression of renal blood flow and glomerular filtration rate. In left-sided heart failure, the left ventricle is unable to increase its output and there is inadequate blood flow to the vital organs.

Allergies

Allergic diseases which occur most frequently in the years past middle

age are bronchial asthma, perennial rhinitis and chronic urticaria.

Asthma is a disease in which bronchospasm occurs and the bronchioles are unable to relax, thereby interfering with respiration. It may be caused by allergy or by heart failure with pulmonary edema. Air remains in the lungs, resulting in poor exchange of gases, distention of the alveoli, and accumulation of secretions. There is a familial tendency in asthma, although the disease may not appear in the chronic form until old age. Occasionally, asthma in the older person may follow a change in climate and living conditions in which unfamiliar dust and pollens are encountered. In some cases it may follow development of sensitivity to some form of bacteria which the patient may have harbored for years. Occasionally it follows retirement from work which brings the person into contact with an aggravating substance about the home for longer periods. Bronchiectasis may complicate asthma as a result of the constant pressure of air upon the weakened bronchial walls. Infection may follow the accumulation of fluid in the dilated bronchioles.

Treatment of asthma may include the use of specific antihistaminic drugs since it has been learned that in most allergic conditions the body produces histamine in abnormally large amounts. Drugs, such as epinephrine, which cause relaxation of the bronchioles may be used and antibiotics, such as penicillin, are often given to combat infection. Aminophylline by vein, mouth or rectum is standard treatment for asthma. Oxygen and digitalis may be ordered if evidence of cardiac complication is present.

Skin tests may be done in an attempt to determine the offending substance. Dust, pillows, hair and other possible causative substances should be sought and eliminated if proved to be exciting agents. Sheets and bedding must be moved slowly and carefully with as little disturbance of dust as possible and the number of persons coming into contact with the patient should be restricted if asthma is thought to be due to allergy. Electric suction cleaners are helpful in preventing dust; damp mops and dampened dusters should be used instead of brooms and dry brushes.

Acute Infections

Acute infections with the exception of pneumonia, influenza and erysipelas are rare in later years of life. However, even the so-called "childhood diseases" may occur, such as whooping cough. For this reason, it is inadvisable to call in the grandmother to care for the child who has this condition. If erysipelas is estimated by age-specific rates, its morbidity will be found to be the greatest in the age range of 60 to 70. The frequency of erysipelas at this stage reflects the poor nutrition of the skin. Itching and eczema are common. The clinical picture may differ from that found in youth in that fever and leukocytosis may be less. The danger of acute pyogenic infection of the kidneys is greater. In regard to all acute infections, circulatory collapse may occur early; respiratory complications and delirium are common; fever is usually less.

Following a coronary thrombosis in patients who exhibit the defence against anxiety known as "denial of illness," indiscretion in diet and exertion may do more harm than would arise from more freedom of activity. Modern treatment of myocardial infarction recognizes the value of early maximal activity.

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* * *

Between the idea and the reality, between the motion and the act, falls the Shadow.

— T. S. Eliot

Liberal education is not composed of subjects that are chunks of frozen fact; they are the powerful tools and engines by which a man discovers and handles facts. They sharpen his perceptions, cultivate his powers of analysis, and teach him to foster the habit of holding a valuable point of view.

The Royal Bank of Canada Monthly Letter, Vol. 43, No. 2.

* * *

What is a communist? One who hath yearnings for equal division of unequal earnings.

— Ebenezer Elliott

What Say the Provinces

School of Nursing University of Ottawa

THE EXECUTIVE COMMITTEE of the Canadian Nurses' Association, at their meeting last February, heard Provincial Reports from the member associations. Several trends may be detected in many of the reports. In spite of an increased registration of practising members several provinces expressed particular concern over the ratio of patients to nurses. Concern was expressed, too, about the lack of qualified instructors and the difficulty of retaining faculty.

Growth of provincial associations is evident in the number of new chapters formed — six of the ten associations formed a total of 16. In an attempt to keep the chapters informed and improve the liaison role of chapter presidents, four provinces held institutes for chapter presidents.

Most provinces mentioned the preparation and submission of briefs to the Royal Commission on Health Services.

There has been active participation in the CNA School Improvement Program and much interest shown in the Study on the Quality of Nursing Service.

Particular activities of each provincial association have been summarized below to show the variety of undertakings in nursing across Canada in the past year.

ALBERTA

1. Revised bylaws to make provision for associate (non-practising) members to have associate membership in the CNA.

2. Organized workshops on Mental Health, Evaluation of Student Nurses and Setting of Student Examinations and Evaluation.

3. Held a seminar on Communication in Supervision and sponsored a course on Care of Premature Infants for graduate nurses.

4. Took part in a two-day Conference on Nursing called by the Minister of Health. An important result was the appointment, by the Minister, of a Nursing Education Survey Committee. The Committee is chaired by Dr. E. D. Scarlett and is at present studying new types of educational programs and problems of nursing recruitment.

BRITISH COLUMBIA

1. Completed a series of 15 regional two-day institutes on Maternal and Child Health and sponsored a similar series on Rehabilitation.

2. Chose as the education-day program for the annual meeting the subject "Pride and Prejudice." It was developed in collaboration with the Department of University Extension and the Council of Christians and Jews.

3. Revised the objectives and curriculum of the psychiatric affiliation program for basic students and planned a conference for head nurses in the teaching hospitals to help them understand how to assist students to apply mental health concepts in the care of patients in the acute hospitals.

4. Is planning courses to help members who wish to return to practise after prolonged absence and is sponsoring a clinical refresher course for head nurses from small hospitals to familiarize them with newer nursing procedures on medical-surgical wards.

5. Has been invited to meet with the director of a new Department of Continuing Medical Education at the University. It is hoped that it will be possible to do joint planning of institutes, on a regional basis, for groups of doctors and nurses.

6. Prepared a Guide for Future Nurses' Clubs.

7. Drew up an outline to clarify the duties of Councillors.

MANITOBA

1. Is developing a recruitment program for schools of nursing and set up a committee to prepare a speaker's kit for use by a panel and another to plan for one "open-house" day a year in each school of nursing.

2. Sponsored an Institute for Nurse Administrators and one for Instructors.

NEW BRUNSWICK

1. Completed a project on the Care of the Geriatric Patient. A brochure by

the same title was compiled and distributed to members.

2. Carried out a study of the quality and quantity of applicants to schools of nursing for 1960 and 1961.

3. Initiated a study, comprised of eight sections, on Legal Implications in Nursing.

4. Plans to begin a province-wide program of psychiatric affiliation for student nurses. Held a three-day institute to formulate plans whereby students can be prepared for experience in psychiatric nursing and assisted in applying the knowledge gained to care of all patients.

5. The Continuing Education Program for graduate nurses at U.N.B. offered four institutes: Evaluating Techniques in Schools of Nursing, Teaching Prenatal Classes, Geriatric Nursing, one for senior public health nurses, and two summer courses: Ward Administration, Clinical Nursing in Medicine and Surgery.

Newfoundland

1. Planned a series of workshops on Curriculum Development, Supervision, Planning a Clinical Program, the Role of the Graduate in relation to the Educational Program, and the Learning Process.

2. Completed a statistical survey on all inactive nurses in the province.

3. Used NLN State Board Test Pool examinations for the first time.

Nova Scotia

1. Revised the Requirements and Recommendations for approved schools of nursing.

2. Established membership in the Nova Scotia Education Association.

3. Sponsored an institute on Clinical Teaching for Nursing Service Personnel. Institutes on Rehabilitation, Pediatric Nursing, Occupational Health and Maternity Nursing were sponsored by Dalhousie University School of Nursing.

Ontario

1. A new regulation for courses for nurses that begin after October 1, 1965 requires Secondary School Graduation Diploma of the general course with at least four options of which one shall be science including both physics and chemistry of Grades 11 and 12.

2. Established a special committee on the socio-economic welfare of nurses.

3. Instigated a Study of Registries which was completed in 1961.

4. Participated in a conference, sponsored by the Ontario Hospital Association, for hospitals conducting schools; it was attended by chairmen of boards, administrators and directors of schools of nursing. Presented concepts, policies and criteria as related to nursing education and other matters.

5. Co-sponsored a conference for head nurses and supervisors.

6. Sponsored, jointly with the CNA, six conferences for head nurses and instructors, the objectives of which were to interpret RNAO educational policies and to assist schools to evaluate their educational programs through use of the CNA self-evaluation guide. Held the first conference for operating room and central supply nurses.

Prince Edward Island

1. Secured the services of a nursing consultant to give guidance in a study of nursing service needs in the province.

2. Arising from a request of the Nursing Advisory Committee to the Hospital Services Commission, a study project of nursing service needs was carried out in a 20-bed surgical unit at Charlottetown Hospital.

3. Participated in the following organizations by membership on their policy-making boards: P.E.I. Branch of Red Cross, P.E.I. Conference on Education, Maritime Hospital Association, P.E.I. Nursing Assistants' Association and Licensure Board.

Quebec

1. Held an institute for clinical instructors, and a one-day conference for operating room nurses on Mass Disaster.

2. Appointed a representative to a special government committee on working conditions in hospitals.

3. Set up a simple guide of nursing hour requirements for various categories of patients to be used by hospitals in determining staffing needs.

4. Participated in the nursing session of the Third World Congress of Psychiatry held in Montreal.

5. Completed and printed a Curriculum Guide for English-language schools of nursing. Some areas of the curricu-

lum guide for French-language schools have been studied and revised.

6. Translated into French the eleventh English edition of *Eliason's Surgical Nursing.*

SASKATCHEWAN

1. Introduced a policy whereby "A nurse who has been an inactive member of the SRNA and who has not been engaged in nursing for a period of five years or longer, shall be required to have at least a one-month, carefully planned and supervised program in the field in which she intends to practise."

2. Held an institute on Maternal and Child Health, sponsored a three-day curriculum workshop, a workshop in psychiatric nursing and several refresher courses at the chapter level.

3. Completed the brochure *A Guide for Evaluation of Nursing Personnel.*

4. Is evaluating the need for a Reference Service and conducted a study on the Needs of Home Care Services in Saskatchewan.

5. Accepted the following recommendations: formation of a central body to establish standards, coordinate and supervise all nursing education programs, and that this body be closely associated or integrated with the University; establishment of a continuing, advisory education committee with representation from all groups preparing nursing personnel and related disciplines.

Advances in Dermatological Therapy

STUART MADDIN, M.D., WILLIAM D. STEWART, M.D., F.R.C.P.(C) *and* JULIUS L. DANTO, M.D.

During the past 10 years or so, the specialty of dermatology has undergone many noteworthy changes. This brief presentation will attempt to outline those aspects of modern therapy that should be of interest to the nursing profession.

IN THE PAST, much dermatological management was on an empirical and non-specific basis. Now, however, many of the therapeutic agents are specific for various skin conditions. The nurse who is responsible for maintaining good dermatologic nursing principles can discharge her duties more rationally if the advances and changes in techniques are familiar to her.

In order to place therapeutic advances in proper perspective, several of the more important basic scientific contributions must be mentioned. A more thorough understanding of the healing process has altered many of the older concepts. The skin antiseptics that were routinely applied in dermatological cases have been proven to be superfluous. The use of occlusive bandages and dressings has largely been abandoned, except under unusual circumstances. They provided a hot, humid environment that caused maceration, interfered with healing and produced an excellent culture medium for bacteria. Therapy tends to be directed toward drying the area and reducing inflammation. Dressings are seldom required. Modern emulsifying and "wetting" agents added to lotions and creams provide excellent spreading and penetrating qualities so that medications applied topically are more effective and more esthetic.

Well-documented reports have shown that a number of popular skin preparations are capable of producing irritating or allergic skin reactions. The chief offenders are the surface anesthetic agents such as the "cain" preparations, and topical antibiotic creams containing penicillin and sulpha compounds. Use of such medications should be discouraged because of their high sensitizing index. Many physicians and nurses are surprised to learn that antihistamine creams and ointments have a similar capacity for *pro-*

ducing allergic reactions on the skin even though these compounds are used systemically for the *treatment* of allergic reactions.

Hospitalized Dermatological Patients

Too frequent use of soaps, detergents and hot water is capable of producing irritation in normal skin. In the presence of most dermatologic disease, these agents must be avoided, unless they are specifically ordered by the attending physician.

Not infrequently the patient hospitalized for a dermatological condition is handled in the same manner as other patients with medical or surgical problems. Such approach is improper. To be more specific:

1. Only a small percentage of dermatological patients need complete bed rest. For the most part they do much better if a considerable degree of activity is permitted.
2. Meals should not be served in bed.
3. Rooms should be kept as cool as possible in order to avoid other dermatological complications such as intertrigo and/or sweat retention.
4. The patient can be made responsible for most or all of the routine topical applications ordered, if he is given proper instruction and is periodically supervised.
5. Unless specifically requested by the attending physician, standard ward medications should not be used, for example, laxatives, aspirin and barbiturates. These preparations can cause dermatological problems.
6. Routine back rubs, sponge bathing or tub baths should be omitted except upon specific orders of the physician.
7. The nursing personnel should be aware of the possibility of the patient taking oral remedies or using proprietary creams or ointments that he has brought into hospital with him. Such remedies can cause further allergic or irritative skin reactions.

The Common Dermatoses

1. *Acne vulgaris.*

This is one of the commonest skin problems that the physician encounters. Acne can hardly be termed a disease because it is so universal. Although the exact mechanism which underlies this process is not fully known there are several fundamental considerations concerning the "acne process" that should be mentioned:

1. Obstruction of the pilosebaceous apparatus is the site of the basic acne lesion. Blackheads or comedones are usually present.
2. Hormonal activity, especially of the androgen fraction, is the probable trigger factor operating in cases of adolescent acne.
3. Acne displays a genetic pattern. Patients who have severe cystic acne frequently give a history of a father or mother who had a similar form.

With the newer therapeutic agents the most severe forms of acne vulgaris can be controlled. By the judicious use of hot sulphur compresses, modern antibiotics and, occasionally in severe cases, the new adrenocorticosteroid drugs, much can be done to prevent or at least markedly reduce scar formation.

Not infrequently members of both the nursing and medical professions "brush off" teenagers or their parents when they seek assistance in overcoming acne by telling them that "they will grow out of it." However, in the process of "growing out of it" many young people develop unnecessary and disfiguring scars that persist for the rest of their lives. For those patients who have marked scarring a simple, safe dermatological procedure called dermal abrasion is available. This procedure, if properly carried out, will eliminate the disfiguring aspect of severe acne scars and, in some cases, will eliminate the scar. The technique can be performed in the doctor's office.

1. The face is chilled by means of an ice pack.
2. A freon type of refrigerant is sprayed over the scarred site until a degree of firmness is obtained.
3. The operator uses a rapidly revolving diamond fraize wheel to abrade the pitted area until it is smooth.
4. The area is covered with dressings for 48 hours, then compresses are used for an additional six to eight days.
5. Postoperative pain is virtually nonexistent for some unexplained reason.
6. The crusts fall off within three weeks. The patient's skin assumes a more normal appearance.

7. The residual redness in the operated sites usually fades and disappears in the next three to eight weeks.

2. *Fungal infections.*

The evidence that has accumulated over the past years since the introduction of Griseofulvin now allows an accurate assessment of this antifungal oral preparation. Simply stated one gram daily in divided doses of 250 mgm. tablets for adults, and one-quarter to one-half gram daily for children will produce a satisfactory therapeutic result in fungal infections of the skin and scalp. Fungal infections of the fingernails are more resistant to therapy. Therapeutic results are measured in terms of months rather than days or weeks. Griseofulvin, when prescribed in the suggested dosages does not produce serious untoward reactions and is tolerated very well by the patient. With this oral antifungal agent the time needed to bring about a clinical cure in previously resistant ringworm of the scalp, skin, and fingernails has been greatly reduced. Griseofulvin has not given satisfactory results in cases of fungal infection of the toenails. It is effective in virtually all types of superficial fungal infections seen in Canada.

3. *Psychosomatic aspects of dermatology.*

The exact role that the emotions play in skin disease is still not known. It is well, therefore, that we should heed the warnings of psychiatrists who are fearful of the unrealistic therapeutic demands being made upon them by too enthusiastic or over-zealous members of the medical profession. Unfortunately, the temptation to diagnose chronic or recalcitrant skin diseases as psychosomatic is very inviting. Because of the basic advances that have taken place in the last 10 years in dermatology there is less of a tendency to "bury" our medical shortcomings under the diagnostic label of psychosomatic disease.

The tranquilizing drugs that are available now have made it possible to treat certain skin problems that have an emotional component in a more rational manner.

4. *Diet and dermatology.*

The very elaborate and sometimes costly dietary substitutions that were formerly requested for those with skin disease have been discontinued for the most part. However, there still lingers in the minds of many people, both lay and professional, some reservations in accepting this uncomplicated approach to diet. A well-balanced diet of standard food items very rarely produces a skin condition or affects an existing one. Some foods such as chocolate, nuts, shell-fish and carbonated beverages containing cola are restricted in acne vulgaris. Acute attacks of urticaria or hives may be due to foods or ingested drugs. In such instances there is usually a history of an attack within thirty minutes to three hours following the ingestion of the particular food or drug. Eczema of infancy (usually atopic dermatitis) may be made worse by certain foods in rare instances, but this tendency lessens and by the end of the first year plays a very minor role.

Hot (in temperature) foods and liquids, and alcoholic beverages may produce flushing and increased temperature of the skin which intensifies pruritus. This has led to the misunderstanding that they may intensify skin disease generally. It is best to avoid their use simply for the comfort of the patient.

5. *Pruritus.*

The patient afflicted with generalized itching is a therapeutic challenge to the attending physician and a potential nightmare for the nurse. Factors that aggravate itching are heat, wool, rough bed sheets, friction and rubbing, perspiration and soap. All of these are found in the hospital environment. The use of colloid along with such oral antipruritic medications as Trimeprazine can be very effective in controlling pruritus.

6. There are three not too common dermatological diseases that have serious systemic manifestation. These conditions are: *systemic lupus erythematosus, pemphigus vulgaris* and *syphilis.*

Prior to the advent of the adrenocorticosteroids the first two diseases were inevitably fatal. Fortunately, proper utilization of steroid drugs and antibiotics will do much to prolong the life of the patient and ameliorate his discomfort. With the introduction of

penicillin and other antibiotics the once dread disease of syphilis has lost its sting in large measure. Newer and specific diagnostic techniques make it possible for the physician to accurately diagnose syphilis if it exists. In earlier times such diagnosis was only possible in the primary stage of the disease and then only if the live Treponema *pallidum* could be visualized under the dark field microscope.

This short treatise does not claim to include every advance that has taken place. The authors have attempted to review the more common, the more practical and in general, the more interesting advances from the nursing point of view.

The Storks Fly Higher

MARGARET MADDEN

Since 1943 the storks have been flying on, steadily and regularly, but beginning last December they have been flying higher.

THINGS HAVE BEEN happening in the School of Nursing of the University of Alberta. There had been correspondence between the School and the secretary of the Central Midwives Board of England and Wales for some time regarding the possibility of the Board's recognition of the University's advanced practical obstetrics course as the equivalent of a part of their midwifery program. Early last summer the Board decided to send someone to evaluate the course.

In October 1961, Miss Mary Williams, matron of Queen Charlotte's Hospital, London, England and past president of the Royal College of Midwives, arrived in Edmonton and remained for more than a week. A program had been planned for her which provided an opportunity to sit in on lectures, visit hospitals and clinics in the city, and discuss the course with the lecturers. She visited St. Joseph's Hospital, Barrhead, Alta., where a graduate of the course is on the staff of the obstetrical ward. A visit to the the Calgary General Hospital was arranged where another graduate is in charge of the case room to which students of the course frequently go for their field experience. Following this visit, Miss Williams wrote a detailled report which was presented to the Board on her return to London.

During mid-December a letter was received by the School from the secretary of the Central Midwives Board, in which he wrote:

> The Board has resolved to recognize nurses who have satisfactorily completed this course, as possessing a qualification the equivalent of their First Certificate. Therefore, they can be admitted to the Roll of Midwives after taking the six months' second period of training in this country and passing the Second Examination. They will, of course, be required to comply with the Board's rules governing the length of time (it is six months) which elapses between first and second period training.

In addition he included in his letter the suggestions which Miss Williams had made.

The School of Nursing, and the University, offer this course to Canadian nurses, with some degree of pride, not only because it is the only one of its kind in Canada, but also because it has gained this recognition from the Central Midwives Board. It is hoped that nurses from all provinces will take advantage of this special opportunity within their own borders.

Don't *say* things. What you *are* stands over you the while, and thunders so that I cannot hear what you say to the contrary.
— EMERSON

Intertrochanteric Fractured Femur

BEVERLEY BOTTER

The amount of inorganic matter increases in the bones of the aged. As one grows older, bones become brittle. They break easily but heal with much difficulty.

MR. MARKS, aged 78, was admitted by ambulance with a swollen right hip and lateral deviation of his right ankle. His diagnosis was intertrochanteric fractured right femur. Severe pain and his advanced age added to the gravity of his condition.

His strong determination to overcome difficulties was one of his special characteristics. It was a factor that definitely influenced his recovery. His attitude seemed to be: This is not my first struggle and probably not my last. So why give up now?

Medical History

On his way to his daughter's house the elderly man slipped and fell upon the icy sidewalk. He felt severe pain when helped to his feet by a passing motorist who took him to a doctor. The doctor advised hospitalization and warned Mr. Marks that he should expect to stay for at least a month.

Investigation

Routine tests were made immediately following admission. *Urinalysis* revealed the presence of glucose. Ten years previously, Mr. Marks had been diagnosed as a very mild diabetic. Although he was not taking insulin, his urine was tested t.i.d. during his hospitalization, as a precautionary measure. The diabetic record at discharge revealed mainly negative results.

A *glucose tolerance test* showed a reading of 116 mgm.%. Normally, the venous blood reaches a peak of 120-160 mgm.%/100 ml., 30 minutes to one hour after glucose is ingested and returns to or near fasting level two hours after ingestion. A second glucose tolerance reading showed a 195 mgm.%.

An *electrocardiogram* and a *chest X-ray* were taken. The chest plate revealed senile emphysema. This indicated the abnormal presence of air in the chest cavity, probably due to old age. The ECG showed rhythmic disturbances of the heart. The results of these tests prompted Mr. Marks' doctor to order digitaline nativelle t.i.d. for two days and then leaf digitalis daily. When this drug is given, the cardiac rate decreases and the contraction of the heart muscle becomes stronger. A digitalizing dose is given initially to slow the ventricular rate and then a maintenance dose is given either orally or intravenously. Before receiving his oral preparation, Mr. Marks' pulse rate was taken for a full minute. This is a precautionary measure to ascertain that the pulse is not less than 60 beats.

Operation

An X-ray of the right femur was taken on the day before operation. This allowed the doctor to observe the position of the bone and enabled him to determine how he would reduce the fracture. A Pugh nailing of the right femur, under general anesthetic, was undertaken. Traction and slight internal rotation were applied to the leg. A drill hole was made in the lateral cortex of his femur and three guide wires were inserted. Then the Pugh nail was driven home. Three stainless steel screws attached the plate portion of the Pugh nail to the femur shaft. The use of internal fixation of a fracture causes least inconvenience to the patient and modifies nursing problems. Progress of bone union and position is usually followed by repeated X-ray examinations. Three weeks after Mr. Marks' operation, an X-ray showed bony union to be good but incomplete.

Nursing Care

At the beginning Mr. Marks was apprehensive about movement in bed. He could be turned gently on his fractured extremity. When turned on the unaffected leg, the fractured limb was kept at the same level as the trunk.

Pillows placed between his legs gave added support. To keep good body alignment, pillows were placed behind his back for support. A fracture board under the mattress provided similar assistance. A footboard at the end of the bed helped to prevent footdrop by supporting his feet in normal position; by lifting the weight of the bedding thus assuring freedom of movement for foot exercises.

With the help of a Balkan frame, Mr. Marks began to assist in his own movements. Through such activity he forestalled thrombosis and embolism and modified the problem of bedpans and changing sheets. He soon began to dangle his legs over his bedside and to sit up for his meals. Later, he was lifted to a large armchair for a restful change of position while his bed was being made. This graduated activity was determined by Mr. Marks' general condition and the security of fixation obtained from the Pugh nail.

The initial shock plus pulmonary, cardiovascular or renal complications are often too much for a frail body to bear. In all patients with fractures, deep breathing exercises are necessary to prevent postoperative pulmonary complications. Mr. Marks was encouraged to breathe deeply and to cough up mucus. Despite a daily bath and good skin care a reddened area on the sacral region appeared soon after his operation. Generous applications of Alphamel ointment and frequent change of position were most beneficial. Mr. Marks was placed on a rubber ring occasionally, but because it put pressure on a greater area, it was used with caution. Gastrointestinal disturbances may arise, such as constipation. This can be prevented to a large extent by careful attention to habits of elimination and diet.

Mr. Marks had a light diet which contained the necessary elements for tissue building and repair, in particular high protein foods, vitamins and calcium. Roughage was included.

Urological problems are prone to develop during immobilization. Intake and output must be estimated until it is determined that kidney function is normal, for there is great danger of renal calculi. Mr. Marks drank a large amount of fluid each day to avoid this complication.

Three weeks after admission Mr. Marks was transferred to a hospital in his home town, so that he could be closer to his daughter. He faced the future cheerfully, anticipating better days ahead.

(*Continued from page 609*)

General Hospital pays tribute to the memory of **Jessie Edith Meigs** '12; **Beatrice Mary (Preston) Menzies** '22 and **Inez Ellen Welling** '23.

* * *

Mary S. Montgomery (Winnipeg General Hospital 06') died on April 9, 1962 in Winnipeg.

* * *

Catherine R. Shea (Baltimore General Hospital, Maryland) died in New York in April 1962. At the outbreak of World War I she joined the St. Francis Xavier University, (Antigonish, N.S.) nursing contingent and went overseas in 1915. She served in France and Belgium and was decorated by the governments of both countries.

* * *

Rena (Ross) Threader (Nicholls Hospital, Peterborough, Ont. '22) died on April 7, 1962.

* * *

June (Rose) Underwood (Toronto General Hospital, Wellesley Division '46) died on March 24, 1962.

Responses to a questionnaire sent to physicians in private practice in the U.S. revealed that 90 per cent had taken post-graduate or continuing medical education courses. About half took courses last year and an even greater percentage intend to do so this year. One third of the physicians who had been students in 1961 were graduated from medical school within the last 10 years; an equal proportion graduated between 1941 and 1950, and almost 10 per cent had graduated more than 30 years ago.

Patterns of Disease, A Parke, Davis publication.

SUMMER HOLIDAY

MOLLY ADSHEAD

Where is my bottle of Sucaryl, and where are my tins of Metrecal? At last we're ready and on our way. We're off to Californ-i-ay!

We skimmed o'er the reaching prairie, burnished with golden grain, With red barns added for contrast down each green country lane.

(You're eating that stack of flapjacks? Just how cruel can you be! This Metrecal is delicious — but can't you spare *one* bite for me?)

We climbed the rolling foothills where sombrero'd cowboys ride. And the sleek brown cattle were grazing on land where the buffalo died.

(You ordered a two-inch sirloin? Just a minute — I'll have one too! This diet seems lacking in protein, so what's a poor gal to do!)

We circled the mighty mountains rearing from prairie sod, Those majestic piles of granite with spires pointing up to God.

(Brook trout all smothered in butter, and apple pie à la mode too? I forgot to mix my Metrecal. Just *half* an order will do!)

We found driftwood by the blue Pacific, and ran on the hard-packed sand. We watched the white-capped breakers roll from Japan to our land.

(Jumbo shrimp deep-fried in batter; crunchy and pink inside. Somehow it just doesn't matter if I soon will be three feet wide!)

We zigzagged through giant redwoods growing since Moses' time, Straight as a million arrows flung upward to the sky.

(Huckleberry pie, deep and juicy, calories three hundred and ten! But then, you must remember, we may never come this way again!)

We entered the charging freeway like a leaf on a swift stream borne, To be whirled on the clover-leaf eddies, and cast on the further shore.

(A hamburger, French fries and ice cream? The standard American meal! If I ate that and *you* sat watching, I know how frustrated *you'd* feel!)

We drove o'er the golden gateway bridging the crystal bay, Where doll houses climb the hillside; in sunshine the white city lay.

(Golden fried, luscious spring chicken, a specialty of the house! When it comes to willpower I find I'm not a lion, but a *mouse!)*

Now we're back home in Alberta, bankrupt, and brown from the sun. And I'm living proof of the adage that travelling *broadens* one!

There are nearly 350 institutions of higher learning in Canada teaching college and university level courses. Of these, 45 have the authority to grant degrees. Eight of them hold their degree-granting powers in abeyance because they are in affiliation or federation with another degree-granting institution. Of the 45 universities, 31 offer master's degrees. Eighteen of the latter offer courses leading to a doctorate.

* * *

Two roads diverged in a wood, and I — I took the one less travelled by, — and that has made all the difference.

— ROBERT FROST

Leisure in the Later Years is the second in a series of pamphlets, dealing with mental health aspects of older people, to be published by the Mental Health Division of the Department of National Health and Welfare, Ottawa. This pamphlet and its predecessor, *Planning for the Later Years,* are available from your provincial and/or local department of health or health unit.

Canada's Mental Health, Vol. 10, No. 4

* * *

Some for renown on scraps of learning dote,
And think they grow immortal as they quote.

— EDWARD YOUNG

About Books

Understanding Interrelations in Nursing by Lester D. Crow, Ph.D. and Alice Crow, Ph.D. 461 pages. Brett-Macmillan Ltd., 132 Water St. S., Galt, Ont. 1961. Price $6.50.

Reviewed by Miss Dorothy Dent, 265 Daly Avenue, Ottawa, Ont.

At the beginning the authors state "Nurses are not robots — neither are the persons with whom they work, patients, physicians, supervisors, fellow students, nurses' aides and members of the patient's family."

No nurse should be mechanical in carrying out her duties, nor in her dealings with those with whom she comes in contact. No nurse should have an empty professional air about her. It does nothing except to satisfy her ego. A nurse should endeavor to develop during her training, and maintain throughout her career, a deep-seated feeling of contentment, happiness, understanding and patience. Her greatest satisfaction will be derived from a feeling of success for her job well done. A nurse must remember that patients are persons. They have families, friends, and also enemies. They worry about the past and fear the future.

Many schools of nursing and university departments of nursing are trying to improve interaction as a means of lessening the quota of student drop-outs at the end of six months. The stresses and anxieties of the student nurse have many contributing factors. The student finds it difficult to satisfy the many persons responsible for her final emergence as a graduate nurse after three years. Once graduated the public tends to place the nurse in an idealistic category, setting her apart from people rather than right in the midst where she belongs. The nurse, at times, finds it difficult to meet this imposed standard — socially, emotionally, sexually and economically. Because she is a dedicated person (or should be) she can achieve through her service a high place of regard among the citizenry at large.

To gain knowledge of herself is an important and necessary lesson for a nurse to learn. With this in mind, I recommend a journey into ourselves to discover who and what we are. Deep within each one of us is not only love but also aggression; not only the impulse to live, but at other times the impulse to death and destruction. Deep within us is fear as well as hope; hate as well as charity. To me the most important question for each nurse is "who am I?" We would have less worry about conformity and about others' opinions if we made more effort to discover who we are. In trying to make this discovery we need to realize we are not exalted individuals. What happens to us also happens to others wherever they may be.

I have strayed in reviewing this book but that is because it is so thought-provoking. At the end of each chapter one finds questions that intensify one's reading of it. This book should be read by all nurses. "Orientation to Study in Nursing," chapter four is excellent and instructive for all nurses during all of life. Chapter seven on "The Nervous System and Endocrine Glands" is very well done.

Chapter 19, "The Nurse and Special Service Relations" is material that no nurse should miss. It deals with moral concepts, ethical standards, personal ideals. There is a slight stress on religious and spiritual values.

The only place I found myself at variance with the authors was in a reference in the preface which mentioned "aiding the nurse to acquire sensitivity." I consider sensitivity an innate or inherited quality. I do admit that through experience and adversity it can become a keener sense.

We know that the mind, the soul, or the dynamic force of the individual (call it what you will) cannot be separated from the body. When the body ceases to function normally, there are deviations in the workings of the mind. We also know that the study of an individual's personality must include a consideration of overt behavior. As a nurse grows in self-knowledge she also develops in her knowledge of others. I feel that as a nurse must do teamwork professionally, she also must do so spiritually. There are few professions through which God can display His wondrous works more effectively than in nursing. To paraphrase St. Luke "A disciple is not *above* his teacher but when he is fully trained he will be *like* his teacher."

Congratulations to the authors! This is indeed a valuable book.

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Introduction to Medicine and Medical Terminology by Louise Espey Bollo, A.B. 356 pages. W. B. Saunders Company, 3207 West Washington Square, Philadelphia. 1961. Price $5.00.

Reviewed by Mrs. Ruth Kielley, 59 Military Road, St. John's, Newfoundland.

Many people entering the field of nursing, or any of the other branches of medicine, feel at the beginning as though they were faced with a foreign language. In this book the author has attempted to remedy this by explaining medical terminology in great detail, with emphasis on the composition of words. In a very general way an over-all view of medicine is given as well.

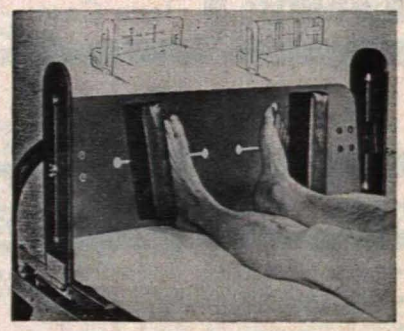
The book is divided into five units. The stage is set by giving a clear picture of the modern day concept of medicine. Emphasis is placed on prevention and mankind's attitude towards this concept. There is a brief history of medicine showing how many ideas and medical terms used in ancient times are still in vogue today.

Units two and three deal with the composition of medical words. The manner in which words are constructed is demonstrated particularly in relation to the role of prefixes, suffixes, and stems. Definitions of various prefixes and suffixes with their relationship to the body and disease are given. Word stems are classified by the original language from which they are derived, by their meaning and reference to anatomical position.

Unit four touches lightly on statistics and the various disease classifications. In addition there is a section dealing with injuries and accidents.

Unit five deals with disease in a very general manner. There is no depth of detail but a general survey is presented. The diseases are grouped according to the systems of the body in many cases. There is a comparatively lengthy discussion of infectious and parasitic diseases, and of a few diseases of specific organs. Nutritional, allergic, metabolic, nervous and mental disorders are included, as well as neoplasms and obstetrical conditions. Signs and symptoms, prognosis, complications, causative agents (where possible), mode of transmission and distribution are presented where applicable. Treatment is mentioned very briefly and nursing care not at all.

The author set out to give the reader a panoramic view of medicine and medical terminology. She has accomplished her aim. The text would serve as an excellent refer-



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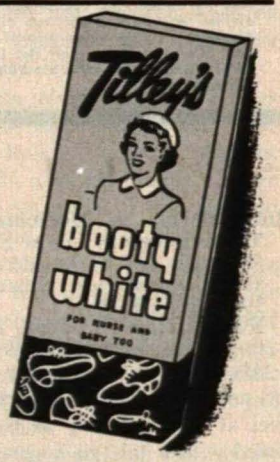

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ence for student nurses, and even as a quick reference for those in the graduate field. The first four units could be of help to people in other branches of medicine, such as medical secretaries and librarians. It helps to make medical terminology more easily understood and more meaningful.

Food, Nutrition and Diet Therapy by Marie V. Krause, B.S., M.S. 716 pages. McAinsh and Company Limited, 1251 Yonge Street, Toronto 7, 3rd ed. 1961. Price $6.75.

Reviewed by Miss Grace Duggan, School of Home Economics, University of Alberta, Edmonton.

The organization of the book is excellent. It is a particularly good text for nurses since it deals with many subjects even if somewhat briefly. It is divided into satisfactory units, making it possible for more than one instructor to use the book with either the same or different groups of students.

I should like to see more Canadian material for use in Canada. I appreciate the Canadian Dietary Standard on page 118 but it is not in the index so is a little difficult to find. I should like to see Canada's Food Rules in print. If they are in the book they are not listed in the index. Material on food supplies, nutritional surveys and other material that would be available from the Nutrition Division, Department of National Health and Welfare, Ottawa, would be most useful. I appreciate the section on geographic and cultural dietary variations.

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Registered Nurses for modern 70-bed General Hospital. Salary $300 - $330 per mo. **Certified Nursing Aides** $195 - $215, 40-hr. wk., liberal policies, yearly increments, residence available. Situated in prosperous Peace River country, French & English population. Apply: Sister Superior, Sacred Heart Hospital, McLennan, Alberta.

Registered Nurse for General Duty (1) for modern 25-bed hospital. Basic salary $315 plus $10 per year in consideration of experience up to $345, room & board $30. Apply to: The Matron, Municipal Hospital, Coronation, Alberta.

General Duty Registered Nurses (2) after April 15th. for busy 35-bed General Hospital situated on pavement 80-mi. east of Edmonton. Gross basic salary $295 per mo. with 8 semi-annual $5.00 increments, salary adjustment for previous satisfactory experience, 40-hr. wk., rotating shifts, 3-wk. vacation, 10 statutory holidays per year, 12 days sick leave yearly, cumulative to 30 days, pension plan, group plans for MSI & Blue Cross, Alberta registration or eligibility for same required. Apply: Matron Superintendent, Viking Municipal Hospital, Viking, Alberta.

General Duty Graduate Nurses for active 76-bed hospital, near Calgary & Edmonton. $285-$335 gross salary for Alberta registered, $275-$325 gross salary for non-registered in Alberta. Excellent personnel policies & working conditions. Apply to: Matron, Municipal Hospital, Brooks, Alberta.

Graduate Nurses (3) for Provost Municipal Hospital, regular duty. Starting salary $295 per mo. with additional $10 per mo. for 1 year or more previous experience, increments of $5.00 each 6-mo. period of employment to a maximum of $325. Nurses' residence available, uniforms laundered free. 3-wk. vacation with pay after 1 year's employment. Apply: Mrs. E. Lindsay, Matron, Box 270, Provost, Alberta.

Public Health Nurse (Qualified) for City Health Dept. Sept. 4/62. Excellent working conditions, including pension plan, month's holiday, hospitalization benefits, etc. Apply to: Supervisor of Nurses, City Hall, Calgary, Alberta.

Public Health Nurses (qualified) required by the City of Edmonton Health Department, salary $3,889 - $4,698 over 5 years, 5-day wk., vacation, sick leave & retirement plan. Apply to: Miss C. Rose, Secretary, Local Board of Health, 770 City Hall, Edmonton, Alberta.

Public Health Nurse for generalized program. Starting salary range from $3,420 - $3,960 depending on qualifications & experience. 5-day work wk., accumulative sick leave, pension plan, car provided for duty. Direct inquiries including qualifications to: Secretary-Treasurer, Grande Prairie Health Unit Board, 10235- 108 Avenue, Grande Prairie, Alberta.

NURSES fully qualified for 30-bed active treatment hospital. New hospital building & recently renovated nurses' residence. Unless definitely interested in coming, please do not apply. Personnel policies sent upon request. Apply to: Mrs. M. Hislop, Superintendent, Municipal Hospital, Bassano, Alberta.

BRITISH COLUMBIA

Director of Nursing for active 23-bed acute General Hospital on Sunshine Coast 50 mi. from Vancouver. Must be eligible for B.C. registration, have O.R. & supervisory experience, and organizing ability. Salary open, health insurance plan, superannuation, two-room suite in residence $15 month. New hospital planned. Please apply with full particulars to: Administrator, St. Mary's Hospital, Garden Bay, British Columbia.

Nursing Supervisor B.C. Registered for new hospital at Golden, British Columbia, picturesque village in the beautiful Canadian Rockies, on C.P.R. & Trans-Canada Highway, 170-miles west of Calgary, Alberta. Please indicate qualifications & salary expected. Full information regarding duties & hospital operation & organization available on request. Apply to: C. F. Collins, Administrator, Golden & District General Hospital, P.O. Box 230, Golden, British Columbia.

Registered Nurse for Operating Room & General Duty Nurses for 40-bed hospital, salaries according to RNABC agreement. 4-wk. vacation, 10 statutory holidays, 1¼ days sick leave per mo., accommodation available in new modern residence. Apply to: Administrator, St. John Hospital, Vanderhoof, British Columbia.

General Duty Nurses for small active hospital. Salary $294 for unregistered Nurses in B.C. $312 registered with yearly increments. Nurses' home available. For further particulars write: The Administrator, Lady Minto Hospital, Ashcroft, British Columbia.

General Duty Nurses for active 30-bed hospital. RNABC policies & schedules in effect also Northern Allowance. Accommodations available in residence. Apply: Director of Nursing, General Hospital, Fort Nelson, British Columbia.

General Duty Nurses for 200-bed General Hospital with School of Nursing. Salary range $297 to $359. Pre-planned shift rotation, B.C. registration essential, 4-wk vacation after 1-yr. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

General Duty & Operating Room Nurses for new 75-bed hospital opening in August. Salary for B.C. registered nurses $309-$374 with one salary increment for 2 years satisfactory experience. Salary for non registered nurses $294, 10 statutory holidays, 4-wk. annual vacation, 1½ days sick leave per mo. cumulative to 120 days. C. U. & C. medical care plan & superannuation, living accommodation available. **CERTIFIED NURSE AIDES:** Salary $200-$221, fringe benefits as above except sick leave cumulative to 60 days. Very active town in Cariboo ranching country. Daily plane, train & bus service to points north & south, 8-hr. drive to Vancouver, B.C. Apply: Director of Nursing, War Memorial Hospital, Williams Lake, British Columbia.

General Duty Nurses for new 82-bed hospital in the Aluminum City. Registered $309 plus $15 differential, 2 years experience $324 plus $15 differential. Room & board available at $45, 40-hr. wk., 10 statutory holidays, 4-wk. annual vacation, superannuation & Medical Plan coverage. Fare advanced, if required. Apply to: Director of Nursing, General Hospital, Kitimat, British Columbia.

General Duty Nurses for 110-bed hospital in northwestern B.C. Salary—non-registered $297, B.C. registered $312-$374. Travel allowance, newly furnished residence available. For full details contact: Director of Nursing, General Hospital, Prince Rupert, British Columbia.

General Duty Nurses for well-equipped 80-bed General Hospital in beautiful inland valley adjacent Lake Kathlyn & Hudson Bay Glacier. Initial salary $324, maintenance $47.50, 40-hr. 5 day wk., 4-wk. vacation. Boating, fishing, swimming, golfing, curling, skating, skiing. Comfortable nurses' residence, rail fare advanced if necessary. Apply: Sacred Heart Hospital, Smithers, British Columbia.

General Duty & Operating Room Nurses for 434-bed hospital with school of nursing. Salary: $309-$374. Credit for past experience & postgraduate training. 40-hr. wk. Statutory holidays. Annual increments; cumulative sick leave; pension plan; 28-days annual vacation; B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

General Duty & Operating Room Nurses for modern regional hospital in a very active community. Starting basic salary $309 for B.C. registered & $294 for non B.C. registered. Allowance made for qualifications & experience. RNABC personnel policies in effect. Planned rotation, rooms available in new nurses' residence at $26 per mo. Apply to: Director of Nursing, Prince George Regional Hospital, Prince George, British Columbia.

Graduate Nurses for 70-bed acute General Hospital on Pacific Coast. Salary for B.C. Reg'd. Nurses $297 with regular increases; Unreg'd., $285. Board & room $25 per mo., 5-day wk., 28 days vacation plus 10 statutory holidays, after 1 year. Apply: Director of Nursing, St. George's Hospital, Alert Bay, British Columbia.

Graduate Nurses for 60-bed modern hospital in resort area on Vancouver Island. R.N. basic $309 with yearly increments according to RNABC personnel policies. Enquiries: Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia.

Graduate Nurse for 31-bed hospital. Salary: B.C. registered $324, non B.C. registered $314 per mo. with annual increments. 40-hr. wk., 4-wk. vacation, 1½ day sick leave per mo. Lodging $11 per mo. Travel refunded from Vancouver after 6 mo. Apply to: Administrator, General Hospital, Ocean Falls, British Columbia.

Graduate Nurses for 20-bed hospital, 35-mi. from Vancouver, on Coast. Salary & personnel practices in accord with RNABC. Bus & train transportation, accommodation available. Apply: Director of Nursing, General Hospital, Squamish, British Columbia.

Nurses (2 by June 1st, 1962) for 30-bed hospital. Salaries as per B.C. Registered Nurses' agreement. Comfortable nurses' home. Apply to: Miss H. Campbell, R.N., Director of Nursing, Community Hospital, Grand Forks, British Columbia.

STOP! Would you like to work in a small 50-bed active, friendly hospital? Permanent & holiday relief nurses required at Langley Memorial Hospital, 35-mi. from Vancouver. Apply to: Director of Nursing, Langley Memorial Hospital, Murrayville, British Columbia.

MANITOBA

Registered Nurses for 12-bed hospital in Lynn Lake, Manitoba. Salary $325 per mo. plus room & board. Group insurance, medical & hospital, pension plan available. For further particulars apply to: W. F. Clarke, Personnel Manager, Sherritt Gordon Mines Limited, Lynn Lake, Manitoba.

Registered Nurses for 165-bed hospital. Starting salary $285. Good personnel policies. Full orientation program. Apply: Nursing Service Officer, Victoria General Hospital, Winnipeg, Manitoba.

Registered Nurses for General Duty for 18-bed hospital. Salary $305 - $345 per mo., full maintenance available in hospital residence for $45 per mo., generous personnel policies. Apply: Administrator, Community Hospital, Reston, Manitoba.

General Duty Nurses (3) for new 85-bed hospital. Good salary & generous personnel policies. Apply: Director of Nursing, Portage Hospital District #18, Portage La Prairie, Manitoba.

NEW BRUNSWICK

General Staff Nurses urgently required to staff 160-bed extension to a General Hospital. Nurses required for Intensive Care Unit, Medical Surgical Units, Pediatrics, Obstetrics, Operating Room & Psychiatry. Starting salary $260 per mo., good personnel policies. Apply: Director of Nursing, Moncton Hospital, Moncton, New Brunswick.

NOVA SCOTIA

Evening Supervisor for 50-bed General Hospital, 40-hr. wk., excellent personnel policies. Apply to: Director of Nursing, Western Kings Memorial Hospital, Berwick, Nova Scotia.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

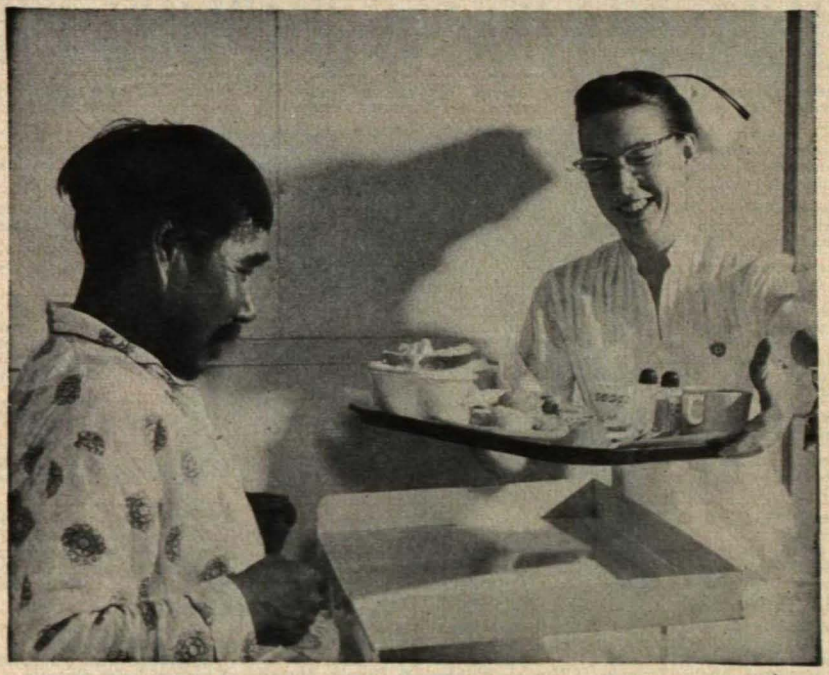
ONTARIO

Director of Nursing (Immediately) for 86-bed hospital with planned extension to 126 beds, building to commence this year. Good personnel policies & furnished apt. in residence. Please apply by letter giving details of qualifications & experience to: Administrator, The Collingwood General & Marine Hospital, Collingwood, Ontario.

Director of Nursing (applications are invited for position) for 106-bed General Hospital with planned expansion. Write: Administrator, Norfolk General Hospital, Simcoe, Ontario.

NURSING WITH

Indian and Northern Health Services



REGISTERED HOSPITAL NURSES
PUBLIC HEALTH NURSES
AND
CERTIFIED AUXILIARY NURSES

For service to Indians across Canada, Eskimos and the population of the Yukon and Northwest Territories.

Those interested in positions at the following locations should write to: Fisher River Hospital, HODGSON, MAN.; Miller Bay Hospital, PRINCE RUPERT, B.C.; Moose Factory Hospital, MOOSE FACTORY, ONT.; Norway House Hospital, NORWAY HOUSE, MAN.; Sioux Lookout Indian Hospital, SIOUX LOOKOUT, ONT.; Nanaimo Indian Hospital, NANAIMO, B.C.

Information on these and other I.N.H.S. positions is available from Indian and Northern Health Services, Department of National Health and Welfare, in Vancouver, Edmonton, Regina, Winnipeg, Ottawa and Quebec, or from the

Director, Personnel Services,

DEPARTMENT OF NATIONAL HEALTH AND WELFARE, OTTAWA

Head Nurses, General Duty Nurses & Certified Nursing Assistants for new 85-bed hospital with modern equipment, situated in a progressive town of 5,000, located 23-mi. from London, Ontario. Postgraduate education preferred, excellent personnel policies, salary commensurate with experience & qualifications, opportunity for advancement. Apply: Director of Nursing, Strathroy Middlesex General Hospital, Strathroy, Ontario.

Registered Nurses for expanding General Hospital, Medical, Surgical, Operating Room & Obstetrical services, at Ajax, Ontario on Highway 401, 20 mi. east of Toronto, hourly bus service to hospital. Salary in accordance with qualifications & experience, increments every 6 mo., sick & vacation time after 6 mo., sick time cumulative to 14 days, 37½-hr. work wk., pension plan, living-in accommodation. Apply to: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario. **Nurses from Europe & United Kingdom,** apply to: Canadian Department of Labor, 61 Green Street, London, W.1, England.

Registered Nurses for 34-bed hospital, min. salary $320, 3-wk. vacation with pay, sick leave after 6-mo. service. **Certified Nurses Assistants** salary $220, 2-wk. vacation with pay. **All staff** — 5-day 40-hr. wk., 9 statutory holidays, pension plan & other benefits. Apply to: Superintendent, Englehart & District Hospital, Englehart, Ontario.

Registered Nurses (2) for expanding General Hospital in resort area. Salary $290 per mo. Residence accommodation available. Apply: Director of Nursing, Huntsville Memorial Hospital, Huntsville, Ontario.

Registered Nurses for immediate & future vacancies in this 42-bed hospital. Starting salary $320. Accommodation in new residence available. Pension plan & other benefits available. For full information apply to: Director of Nursing, New Liskeard & District Hospital, New Liskeard, Ontario.

Registered Nurses: The Toronto General Hospital will accept application from registered nurses with experience in psychiatric nursing for a new unit to be opened shortly. Apply: Director of Nursing, Toronto General Hospital, 101 College Street, Toronto, Ontario.

Registered Nurses for new wing opening October, 1962. Excellent personnel policies & employee benefits. Apply to: Director of Nursing, St. Catharines General Hospital, St. Catharines, Ontario.

Registered Nurses. Applications & enquiries are invited for general duty positions on the staff of the Manitouwadge General Hospital. Excellent salary & fringe benefits. Liberal policies regarding accommodation & vacation. Modern, well-equipped 33-bed hospital in new mining town, about 250-mi. east of Port Arthur & north-west of White River. Pop. 2,700. Nurses' residence comprises individual self-contained apts. Apply, stating qualifications, experience, age, marital status, phone number etc. to the Administrator, General Hospital, Manitouwadge, Ontario. Phone TAylor 6-3251.

Registered Nurses for 60-bed hospital, starting salary $300 gross per mo., good personnel policies. Apply: Superintendent, St. Marys Memorial Hospital, St. Marys, Ontario.

Registered Nurses for all services including Psychiatry & Operating Room. Salary range: $305 to $335 per mo. Personnel manual sent on request. Apply: Director of Nursing, The Wellesley Hospital, 160 Wellesley St. E., Toronto 5, Ontario.

Registered Nurses & Certified Nursing Assistants for modern 75-bed hospital. Starting salaries — R.N.'S $310 per mo., C.N.A.'S $220 per mo. Single room accommodation available in the residence. Dryden (population 6,500) an industrial town, also center of extreme tourist area, is conveniently located midway between Winnipeg & the Canadian Lakehead. For further information regarding personnel policies, community activities, etc. please call or write: The Director of Nursing, Dryden District General Hospital, Dryden, Ontario.

Registered Nurses & Certified Nursing Assistants for 160-bed accredited hospital. Starting salary $320 & $220 respectively with regular annual increments for both. Excellent personnel policies including 5-day wk. Hospital of Ontario pension plan. Residence accommodation available. Assistance with transportation can be arranged. Apply: Director of Nurses, Kirkland & District Hospital, Kirkland Lake, Ontario.

Registered Nurses & Certified Nursing Assistants for 26-bed hospital. R.N. minimum salary $320, maximum $370, 28-day vacation after 1 yr. C.N.A. minimum salary $232, maximum $265, 2-wk. vacation after 1 yr., 3-wk. after 2yr. Credit for past experience, $5.00 increment every 6 mo., 40-hr. wk. 8 statutory holidays. Room & board $45 per mo., 1-day sick leave per mo. Apply to: Mrs. G. Gordon, Superintendent, District Memorial Hospital, Box 37, Nipigon, Ontario.

Registered Nurses for General Duty for 28-bed General Hospital, located in mining & resort area, basic salary $300 - $315 per mo., 6 monthly increments, 4-wk. vacation after 1-yr. Residence accommodation $30 per mo. For further particulars apply to: Miss J. Scollie, Matron, Margaret Cochenour Memorial Hospital, Cochenour, Ontario.

Registered Nurses for General Duty for 14-bed modern newly-built hospital. $320 per mo., 40-hr. wk., 3-wk. vacation, usual fringe benefits. Apply: Hornepayne Community Hospital, Box 190, Hornepayne, Ontario.

Registered Nurses for General Duty in all departments including premature & new-born nursery, Isolation, Emergency & Recovery Room. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Registered Nurses for General Duty & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 80,000 people. **Salary: $305 per mo.** with annual merit increments, plus **annual bonus plan,** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply: Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered Nurses for General Duty in modern 18-bed Private Hospital in iron mining town, 140 mi. north of Sault Ste. Marie, Ontario. Starting salary $290 min. to $330 max. for experience, less $20 per mo. for maintenance. Excellent accommodations & personnel policies, transportation allowance after 6-mo. service. **Operating Room Nurse** starting salary $310 min. with postgraduate course, $350 max. with 3-yr. experience or more. Apply: Superintendent of Nurses, Miss O. Keswick, Lady Dunn Hospital, Wawa, Ontario.

Registered General Duty Nurses (immediately) for new modern 35-bed hospital located in Almonte, 30-mi. from Ottawa. Good personnel policies. Apply to: The Director of Nursing Service, General Hospital, Almonte, Ontario.

Registered or Graduate Nurses for modern 100-bed hospital located in summer resort district, 40-mi. from Ottawa. Apply: Director of Nursing, Public Hospital, Smiths Falls, Ontario.

General Staff Nurse for 163-bed Tuberculosis Sanatorium. Good personnel policies, residence accommodation available. Apply: Director of Nursing, Sudbury & Algoma Sanatorium, Sudbury, Ontario.

Registered Nurses for Staff Duty & Operating Rooms in General Hospital. All patients' services in new modern building opened in November 1960. Good salary & personnel policies. Apply to: Director of Nursing, Arnprior & District Memorial Hospital, Arnprior, Ontario.

THE HOSPITAL for SICK CHILDREN

YOU RECEIVE THE ADVANTAGES OF:

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APPLICATIONS FOR GENERAL DUTY POSITIONS INVITED

FOR INFORMATION CONTACT:

THE DIRECTOR OF NURSING

555 UNIVERSITY AVENUE, TORONTO, CANADA

General Duty Nurses Male & Female & Certified Nursing Assistants (Immediately) for 86-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach and great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

General Duty Nurses for an accredited 66-bed hospital. Starting salary: $305. Excellent personnel policies, pension plan, residence accommodation only 10 min. from downtown Buffalo. Apply: Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

General Duty Nurses for modern 100-bed hospital. Registered start at $300 monthly, Graduates $250 - $285; 40-hr. wk., benefits include accident, sickness & life insurance, hospital & medical insurance plans, & O.H.A. Pension Plan. **Male Nurse,** graduate or registered also needed. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario.

General Duty Nurses for 100-bed hospital, up-to-date facilities in a beautiful location on the shore of Lake Erie. Salary $285 per mo. with recognition for P.G. courses, 40-hr. wk. Residence available. Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

General Duty Nurses for 100-bed modern hospital, south western Ontario, 32 mi. from London. Salary commensurate with experience & ability; $300 basic salary. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital, Tillsonburg, Ontario.

Staff Nurses for 350-bed General Hospital located in downtown Toronto, rotating hours of duty, attractive personnel policies, planned orientation & in-service education program. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario.

Operating Room Nurse (experienced) for 100-bed General Hospital. Salary $350, room & board, if desired, $50 per mo., good personnel policies & O.H.A. Pension Plan in effect. For further particulars apply: Director of Nurses, Lady Minto Hospital, Cochrane, Ontario.

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, ear, eye, nose & throat & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Public Health Nurse (qualified) for generalized program. Salary range, pension plan & other personnel policies given on request. Applicant must have car. Apply to: Dr. W. H. Cross, Muskoka District Health Unit, Box 1019, Bracebridge, Ontario.

Public Health Nurses (Qualified) allowance for experience, car allowance, pension plan. For further information write: Dr. G. Murray Fraser, Director, Brant County Health Unit, Brantford, Ontario.

Public Health Nurse (Qualified) for the Kent County Health Unit — generalized program. Starting salary: $3,900; salary schedule; allowance for experience; pension plan. 1-mo. vacation. Car & uniform allowance. Direct inquiries to: Sherman Brown, Secretary-Treasurer, Kent County Board of Health, 21 Seventh St., Chatham, Ontario.

Public Health Nurses (qualified) Salary $3,700 to $4,700, annual increment $200, car provided or car allowance. Apply to: Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Box 337, Cobourg, Ontario.

Public Health Nurse (preferably bilingual) qualified for generalized program in town of Elliot Lake. Salary range $4,200-$5,200. annual increment $210, 5-day wk., 4-wk. vacation. Provide own transportation, group insurance, hospitalization & P.S.I. employer shared. Apply to: Dr. J. P. Moody, Medical Officer of Health, Suite 17, Plaza Building, Elliot Lake, Ontario.

Public Health Nurse for Town of Hanover, starting September 1, 1962. For further information write to: Duncan McCallum, Secretary, Board of Health, Box 596, Hanover, Ontario.

Public Health Nurse (qualified) September, generalized program, minimum salary $3,600, 4-wk. vacation usual fringe benefits, car allowance. Apply stating salary expected to: Dr. R. V. Peters, M.A., M.D., D.P.H., Lennox & Addington County Health Unit, Napanee, Ontario.

Public Health Nurses (qualified) for generalized program with City of Peterborough. Personnel policies available on request. Apply to: J. R. Anderson, M.D., D.P.H. Medical Officer of Health, City Hall, Peterborough, Ontario.

Public Health Nurses (qualified) for generalized program including some bedside nursing. Salary $3,650 to $5,500, annual increment $200. Employer-shared pension plan, group insurance & P.S.I. Located 25-mi. from Toronto. Apply to: Dr. F. B. Wishart, Director, Ontario County Health Unit, Pickering, Ontario.

Public Health Nurses (qualified) for generalized program. Salary $3,720 - $4,520 (more in rural areas). Cars provided, pension plan, sick leave, other benefits. Apply to: Mrs. Muriel McAvoy, Secretary-Treasurer, Porcupine Health Unit, 70 Balsam Street South, Timmins, Ontario.

Pubic Health Nurse required by City of Waterloo, duties to commence September 1962. Personnel policies on request. Apply: Dr. P. A. Voelker, Medical Officer of Health, 36 Young Street West, Waterloo, Ontario.

Nurse with certificate in Public Health Nursing for Stormont, Dundas & Glengarry Health Unit in the Seaway Valley area. Generalized program. Min. salary $3,700 with allowance for experience up to the maximum. Annual increment, transportation allowance, attractive personnel policies which include 3-wk. vacation, pension plan, group insurance, hospital insurance with employer paying 50% of the cost. Apply in writing giving qualifications & experience to: Dr. Paul S. deGrosbois, Medical officer of Health, Box 1058, Cornwall, Ontario.

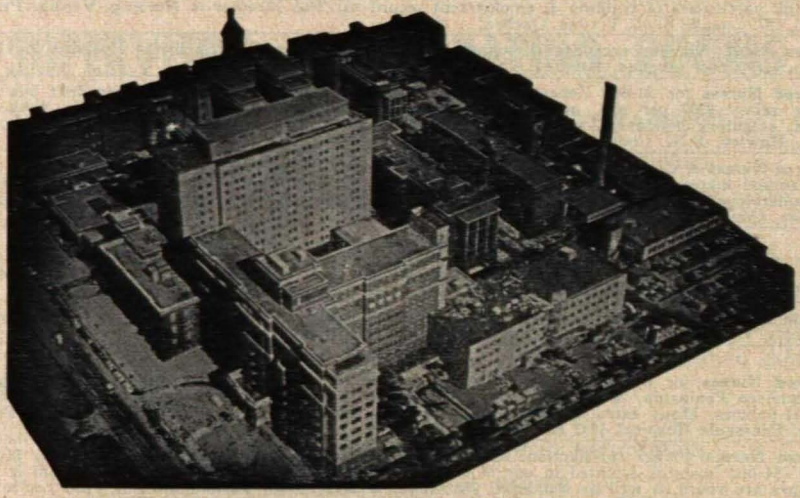
BERMUDA

Instructor to be responsible for Nursing Assistant program. For full information, apply: Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write: Matron, King Edward VII Memorial Hospital, Bermuda.

QUEBEC

Operating Room Supervisor for modern, accredited 55-bed hospital. 40-hr. wk., 1-mo. vacation. Living accommodation available in new motel-style nurses' residence. Apply stating qualifications to: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.



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Registered Nurses and Certified Nursing Assistants
for Medical and Surgical Services
including newly opened Neurosurgical and Cardiovascular Units
Rewarding Experience — Excellent Personnel Policies

For information write to:

Director of Nursing, Toronto General Hospital, 101 College Street, Toronto 2, Ontario

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GENERAL DUTY NURSES FOR ALL DEPARTMENTS

Gross salary $320 monthly with annual increments for 3 years to $350.

Until registration in Ontario is established — $295.

Rotating periods of duty — 40 hour week, 8 statutory holidays annually — Annual vacation 21 days after one year.

Annual sick time 12 days after one year, cumulative to 18 days. Hospitals of Ontario Pension Plan.

Ontario Hospital Insurance and Physicians' Services Incorporated, 50% payment by hospital.

Apply:

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO.

Nursing Instructor (Psychiatric) for large affiliate, postgraduate & nursing assistant program. Apply giving full particulars of training & employment record to: The Director of Nursing, Verdun Protestant Hospital, 6875 Lasalle Blvd., Verdun, Quebec.

Assistant Head Nurses; excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered Nurses for 30-bed General Hospital, 50 mi. from centre of Montreal, excellent bus service. Starting salary $300 per mo., salary increased as recommended by ANPQ, 40-hr. wk. 4-wk. annual vacation, statutory holidays, 2-wk. sick leave, Blue Cross paid, living accommodation available. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Quebec.

Registered Nurses & Certified Nursing Assistants for modern 55-bed General Hospital, salary $300 per mo., 5 semi-annual increases, 40-hr. wk., 4-wk. vacation. **Certified N.A.** starting salary $210, 3-wk. vacation, accommodation available in new motel-style residence. Apply: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.

SASKATCHEWAN

Director of Nursing for 22-bed hospital, salary & other benefits according to SRNA personnel policies, pension plan, new nurses' residence, good train & bus service. Apply: Secretary-Manager, Memorial Union Hospital, Wolseley, Saskatchewan.

Associate Director of Nursing Education for School of Nursing — 60 students. New 200-bed General Hospital. Apply: Director of Nursing, Yorkton Union Hospital, Yorkton, Saskatchewan.

U.S.A.

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses Career satisfaction, interest & professional growth unlimited in modern, JCAH accredited 254-bed hospital. Located in one of California's finest areas, recreational, educational & cultural advantages are yours as well as wonderful year-round climate. If this combination is what you're looking for, contact us now! **Staff Nurse** entrance salary $370 with automatic increases to $435 per mo., supervisory positions at increased rate. Special area & shift differentials paid. Excellent benefits including Blue Cross hospitalization & surgical coverage & liberal personnel policies. Professional staff appointments available in all clinical areas to those eligible for California licensure. Write today: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses (Come to sunny California) **Staff Nurses for permanent positions,** various departments, days, eves., nights. Excellent starting salary, increments, benefits & working conditions in one of the largest & finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California.

Registered Nurses for accredited 170-bed hospital in residential area. Excellent benefits & starting salary, near beaches, Los Angeles, Hollywood, mountain resorts & colleges. Write: J. M. Williams, St. Luke Hospital, Pasadena, California.

Registered Nurses for private 258-bed hospital for men, women & children. Staff Nurse salaries from $355 - $435, differentials for evenings, nights, communicable disease, operating room & delivery. Opportunities in all clinical areas. Holidays, vacations, sick leave & health insurance. California registration required. Applications & details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Starting salary $350 plus $22.50 shift differential. provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

Registered, General Duty & Operating Room Nurses for modern 74-bed District Hospital, midway between San Francisco & Los Angeles, California. Starting salary $350 per mo., 40-hr. wk., living quarters available. Contact: Administrator, Tulare District Hospital, 869 Cherry Avenue, Tulare, California.

Attention! General Duty Nurses 400-bed fully accredited County Hospital located 2-hr. drive from San Francisco, ocean beaches & mountain resorts in modern & progressive city of 35,000. 40-hr. 5-day wk., paid vacation, paid holidays, pd. sick leave, retirement plan, social security, & insurance plan. Accommodations in nurses' home, meals at reasonable rates, uniforms laundered without charge. Starting salary $376 per mo. plus shift & service differentials. Must be eligible for California Registration. Write Director of Nursing, Stanislaus County Hospital, 830 Scenic Drive, Modesto, California.

Staff Nurses for new modern 800-bed General & Tuberculosis Institution in beautiful San Joaquin Valley city — no smog — no snow — 235,000 in metro. area, midway between Los Angeles & San Francisco, close to 3 National Parks, 2 colleges & other cultural advantages. Full maintenance available. Immediate appointment. $4,320 to $5,400 per year. Apply immediately to: Director of Personnel, Fresno County Civil Service, Room 101, Hall of Records Building, Fresno 21, California.

Staff Nurses for 200-bed General Hospital in the heart of Los Angeles cultural & educational center. General Duty $360 per mo., min. days; $35 differential for 3-11 & $30 differential for 11-7. Time and ½ over 40-hr. wk., Social security, State disability insurance, 2 wks. vacation end of 1 yr., 3 wks. after 5 yrs., 7 paid holidays, 12-day sick leave. Cotton uniforms laundered, nurses' residence $10 per mo. Graduates of accredited schools, California license obtainable immediately. Promotions made from staff whenever possible. Apply: Mary Topper, R.N., Director of Nurses, Santa Fe Hospital, 610 South St. Louis Street, Los Angeles 23, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

Staff Duty positions in private 428-bed hospital, non-registered graduates acceptable. Liberal personnel policies & salary. Write to: Personnel Director, Hospital of the Good Samaritan, 1212 Shatto Street, Los Angeles 17, California.

General Duty Nurses for various departments including surgery for 72-bed hospital. Starting salary $375 per mo. with periodic increases & fringe benefits. College town, tourist area, ideal climate. Contact: Superintendent, Alamosa Community Hospital, Alamosa, Colorado.

Obstetrical Supervisor for 30-bed brand new O.B. Dep't. in 200-bed hospital. Responsible for supervision & coordination of nursing care of separately staffed Labor & Delivery' Nursery & Post-Partum areas, facilities include Post-Partum Recovery Room & Rooming-in Units, prefer B.S. in Maternal & Child Health or P.G. in Obstetrics with previous supervisory experience. Salary commensurate with qualifications. Write: Director of Nursing, Highland Park Hospital, 718 Glenview Avenue, Highland Park, Illinois.

SUPERVISOR OF OPERATING ROOMS

Applications for this senior administrative position are invited.

Special preparation and administrative experience essential.

Operations per month average 2,000 in all surgical specialties.

Further information supplied on request.

Appointments to nursing positions are available.

Good personnel policies in effect including medical welfare plan, 40 hour week — four weeks vacation. In-Staff Education program well established during winter months.

Salary $297 - $359 per month
with consideration for experience or special preparation.

SUMMER VACATION RELIEF

Appointments for the 1962 summer vacation program are now available at $297 or $311 per month with approved experience.

For further details concerning the above please apply to:

PERSONNEL DIRECTOR, THE VANCOUVER GENERAL HOSPITAL,
10th AND HEATHER STREETS, VANCOUVER 9, BRITISH COLUMBIA.

REQUIRED IMMEDIATELY

THREE INSTRUCTORS OF NURSING

SCHOOL OF NURSING — BRANDON GENERAL HOSPITAL

STUDENT ENROLLMENT 60

HOSPITAL BEDS 220

Post-basic preparation in
Teaching and Supervision required,
experience desired.

Recognition given for preparation and experience

For further particulars apply to:

PERSONNEL OFFICER
BRANDON GENERAL HOSPITAL
BRANDON, MANITOBA

Graduate Nurses (Professional) Choose a career at Chicago's renowned medical-teaching center. Various staff & special assignments available to provide a work setting compatible with your interests & experience. Starting salary to $420 per mo., plus $40 evening differential & premiums for special assignments. Fringe benefits include vacation to 4-wk. per year, 8 paid holidays, cumulative sick leave, Blue Cross & pension plan, private rooms in modern residence building. Your inquiries are invited: Director, Nursing Service, Dept. C.J.N., Mount Sinai Hospital, 2750 W. 15th Place, Chicago 8, Illinois.

Operating Room Nurses for modern 200-bed General Hospital along the shores of Lake Michigan, 30-min. from Chicago. Progressive salaries and policies. Live in modern nurses' bungalows adjacent to hospital & enjoy social, cultural & educational advantages of Chicago. 6-room brand new operating suite, utilizing most current "nurse saving" methods & equipment. If you're a confirmed OR nurse you'll be right at home in our OR! If you feel you might be interested in OR (but aren't sure) our OR will convert you, beyond any doubt. Contact: Director of Nursing, Highland Park Hospital, Highland Park, Illinois.

Registered Nurses (Immediate full-time openings) Obstetrics, Medical, Surgical. Starting salary $400-$420, generous benefits. Apply: Personnel Department, Lake Forest Hospital, Lake Forest, Illinois.

Staff Nurses & Licensed Practical Nurses (Openings in several areas, all shifts.) 37½-hr. work wk., in small community hospital, 2-mi. from Boston. Living quarters available. Minimum starting pay $73 R.N.'s; L.P.N.'s $61 per wk. Experience considered, differentials for reliefs, nights. Contact: Miss Elizabeth Hewitt, Assistant Director of Nurses, Chelsea Memorial Hospital, Chelsea, Massachusetts.

Staff Nurses 380 bed hosp. new 120 med-surg. unit. Trans. pd. 1st class air to Albuq. and return within U.S. in exchange for 1-yr. emp. contract. Come to New Mexico "Land of Enchantment." Career opportunities, largest pvt. JCAH accredited hosp. in state; near U. of New Mexico, R.N. & B.S. pgm. Practical Nurse pgm. accredited state & NAPNE. Vacancies, Med-Surg. & occasionally O.B., Peds. & O.R., salaries $315 per mo. even., night or O.R. with call; 6-mo. increases up to $375; days $300 per mo. with increases up to $360. Rotation from day duty is required only when no person desiring permanent P.M. of night tour is available. Liberal personnel policies include: optional Blue Cross, Discount Hosp. Services, pd. sick leave cumulative to 5 wks., annual physical exam., vacation 1 yr. — 2 wks., 2 yrs. — 3 wks. 5 yrs. — 4 wks. Active inservice pgm. Occasional vacancy hosp. owned apts. New Mexico licensure as professional nurse & U.S. Citizenship (or Immigration Visa) required. Write or call collect: Mrs. Emily J. Tuttle, Dir. of Nursing, Presbyterian Hospital Center, 1012 Gold, S.E., Albuquerque, New Mexico. Phone 243-5611.

Courses FOR R.N.'S N.Y. POLYCLINIC MED. SCH. & HOSP. — in heart of Manhattan — 6-mo. courses in: O.R. NURSING OPD. NURSING, MED.-SURG. NURSING. Classes 4 times yrly: Mar., June, Sept., Dec. Room, meals, Medical Care & monthly cash stipend. Positions available to graduates of our Courses. For information write: Director of Nursing Education, 345 W. 50 St., N.Y.C., NEW YORK.

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric & pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th. Street, Cleveland 6, Ohio.

Staff Nurses for large modern tuberculosis hospital, suburban Cleveland, Ohio. Monthly salaries start at $375 days, $407 evenings, $396 nights, with semi-annual increments, 5-day work wk., paid vacation & 6 holidays, liberal sick leave, comfortable accommodations in nurses' residence at low rate. Learn & earn at a progressive accredited hospital in a growing community. Write: Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio.

Registered Nurse (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary starts at $372. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland 1, Oregon.

Obstetrical Supervisor responsible for the administration of the Obstetrical Department, for 575-bed hospital, salary $5,100 with increases to $5,460. New $3,500,000 building to open in fall. Entirely new modern Obstetrical Department in new building. Hospital has a large school with large faculty. Obstetrical Instructor carries the responsibility for teaching obstetrical nursing & supervision of students. Obstetrical supervisor assists with orientation & supervision of students. School of nursing has full accreditation with NLN. Retirement plan in addition to Social Security, hospital pays 5% of salary into fund & employee pays 3%. After 5 years, hospital provides life insurance policy for employee equivalent to one year's salary, hospital pays the policy, other liberal personnel policies, attractive working conditions, each room in nurses' residence has its own private bath & shower. Hospital located in a beautiful 40-acre park. Community has many cultural opportunities. One college in city, 4 universities have extension centres or extension courses. Qualifications: Baccalaureate degree with preparation or experience in obstetrical nursing. Apply: Director of Nurses, The Reading Hospital, Reading, Penna.

Science Instructor to teach Chemistry & Microbiology for 575-bed hospital with a $3,500,000 building ready to open in fall. Teaching & laboratory facilities excellent. School has full accreditation from NLN. There are 25 Nurse Instructors on faculty. Salary for assistant instructor $4,500-$4,860 with opportunity for promotion to full instructor in Science Department. Lectures given by Albright College Professor. School has 2 nurse instructors to teach the laboratory portion of the course. One class a year admitted. Retirement plan in addition to Social Security. Hospital pays 5% of salary into fund & employee pays 3%. After 5 years hospital provides life insurance policy for employee equivalent to one year's salary. Hospital pays the policy. Other liberal personnel policies, attractive working conditions, each room in nurses' residence has its own private bath & shower, hospital located in a beautiful 40-acre park, community has many cultural opportunities, one college in city, 4 universities have extension center or extension courses in city. Qualifications: Licensed Nurse with Baccalaureate degree with courses in nursing education. Apply: Director of Nurses, The Reading Hospital, Reading, Penna.

Assistant Nursing Arts Instructor — 5 other full-time instructors with no administrative responsibilities. For 575-bed hospital & opening a $3,500,000 building in fall. Salary $4,500 with increases to $4,860 & opportunity for promotion with salary to $5,460. Two intensive care units in new building. School has full accreditation from NLN. There are 25 nurse instructors, Sciences taught by Albright College. Retirement plan in addition to Social Security, hospital provides a life insurance policy for employee equivalent to one year's salary, hospital pays the policy. Other liberal personnel policies, attractive working conditions. Each room in nurses' residence has its own private bath & shower. Hospital located in a beautiful 40-acre park. Community has many cultural opportunities. One college in city, 4 universities have extension center or extension courses in city. Qualifications: Baccalaureate degree with courses in nursing education. Apply: Director of Nurses, The Reading Hospital, Reading, Penna.

PRESBYTERIAN-ST. LUKE'S HOSPITAL

CHICAGO, ILLINOIS

LOCATION: 10 minutes west of Chicago's Loop. With 822 beds, Presbyterian-St. Luke's is the only private hospital in the world's largest medical center.

SALARY: Staff nurses, $400 to $430 per month. $40 or $30 differential for evenings or nights. Sick leave, social security, and pension plan also available. In addition to regular vacations, a bonus vacation of two months is given after three years' service.

HOUSING: Attractive apartments are available locally. Register of living units provided by the hospital.

SOCIAL: All of Chicago's exciting attractions are only minutes away. Some of the country's finest universities are located here, as well as museums, symphonies, legitimate theatre and other cultural attractions.

Please address your inquiry to: Miss Eunice Lenz
Director of Nursing Service
Presbyterian-St Luke's Hospital
Chicago 12, Illinois

NURSES, REGISTERED

250-bed General Acute Hospital, Centrally located in SAN FRANCISCO, CALIFORNIA

IMMEDIATE day, evening and night positions available for nurses in:

SURGERY, CARDIAC AND INTENSIVE CARE, GENERAL STAFF DUTY

Qualified applicants guaranteed positions for visa purposes.

SALARY RANGE from $365-$435 plus $36.50 P.M. shift (3 - 11:30 P.M.) and specialty differentials, medical benefits and liberal holiday and vacation benefits.

GRADUATE medical resident program with University of California Medical School in General Surgical, Neurological, Ortho, and Plastic Surgery.

For further information, please write to:

MISS LOIS JAHN, DIRECTOR OF NURSING, FRANKLIN HOSPITAL, 14th and Noe Sts., San Francisco, Calif.

Clinical Instructor to teach a portion of Medical & Surgical Nursing, for 575-bed hospital with a new $3,500,000 building ready to open in the fall. Salary for faculty with no previous teaching experience $4,860 with increases to $5,460. Starting salary $5,100 for qualified instructors with 2 years' teaching experience. School of Nursing enlarging, increasing size of faculty. 12 full-time Medical & Surgical instructors with no administrative responsibilities. Also 2 full-time Dietician instructors in the Clinical area. Two intensive care units in new building, school has full accreditation from NLN. There are 25 Nurse Instructors. Sciences taught by Albright College. Retirement plan in addition to Social Security. Hospital pays 5% of salary into fund & employee pays 3%. After 5 years hospital provides a life insurance policy for employee equivalent to one year's salary. Hospital pays the policy. Other liberal personnel policies, attractive working conditions. Each room in nurses' residence has its own private bath & shower. Hospital located in a beautiful 40-acre park. Community has many cultural opportunities. One college in city. 4 universities have extension center or extension courses in city. Qualifications: Baccalaureate degree with courses in nursing education. Apply: Director of Nurses, The Reading Hospital, Reading, Penna.

Evening Clinical Instructor to work with the students in the clinical area from 3:00 to 11:00 P.M. for 575-bed hospital with a $3,500,000 building ready to open in the fall, 2 intensive care units are in new building. School has full accreditation from NLN. There are 25 Nurse Instructors. Sciences taught by Albright College. Starting salary for instructor with no previous teaching experience $4,980, increases up to $5,580, Instructors with previous teaching experience start at $5,220. The school has 10 full-time Medical & Surgical Instructors on days. Also a full-time Dietician Instructor in the clinical area. Retirement plan in addition to Social Security. Hospital pays 5% of salary into fund & employee pays 3%. After 5 years hospital provides a life insurance policy for employee equivalent to one year's salary. Hospital pays the policy. Other liberal personnel policies, attractive working conditions. Each room in nurses' residence has its own private bath & shower. Hospital located in a beautiful 40-acre park. Community has many cultural opportunities. One college in city, 4 universities have extension center or extension courses in city. Qualifications: Baccalaureate degree with courses in nursing education. Apply: Director of Nurses, The Reading Hospital, Reading, Penna.

Pediatric Instructor to teach a portion of pediatric nursing. 2 **Pediatric Instructors** for 575-bed hospital opening a new $3,500,000 building in the fall. Starting salary for instructor with no previous teaching experience is $4,860 with increases to $5,460. Instructors with previous teaching experience start at $5,100. School of Nursing enlarging & increasing the size of the faculty. School has 25 Nurse Instructors with no administrative responsibilities. Sciences taught by Albright College Professors. Entirely new & modern Pediatric Department in new building. School has full accreditation from NLN. Retirement plan in addition to Social Security. Hospital pays 5% of salary into fund & employee pays 3%. After 5 years the hospital provides a life insurance policy for employees equivalent to one year's salary. Hospital pays the policy. Other liberal personnel policies, attractive working conditions. Each room in nurses' residence has its own private bath & shower. Hospital located in a beautiful 40-acre park. Community has many cultural opportunities, one college in city, 4 universities have extension centers or extension courses in city. Qualifications: Baccalaureate degree with courses in nursing education. Apply: Director of Nurses, The Reading Hospital, Reading, Penna.

Staff Nurses (All Clinical Services) Base salary $319, differential for 3-11 and 11-7 shifts, liberal personnel policies incude sick leave, retirement plan, 3-wks. vacation & laundry of uniforms. Orientation & in-service programs — housing available on campus or in vicinity of hospitals. Apply: Director of Nursing Service, The University of Texas-Medical Branch Hospitals, Galveston, Texas.

Registered Nurses for completely modern 299-bed hospital. Starting salary $345 per mo., 40-hr. wk., $20 differential for P.M. shift; $10 differential for night shift. Additional $10 differential paid for obstetrics, nursery, operating room & psychiatric services. 7 paid holidays, paid sick leave, paid health & life insurance, liberal vacations, free employee parking, low cost cafeteria. Please write: Mrs. Dorotha L. Stuart, Personnel Director, Community Hospital, Fresno 15, California.

Registered Nurses (Work where it is fun to live! come to sunny California) for 274-bed hospital, located within walking distance of the beaches & a few minutes drive from Beverly Hills, Hollywood, & Los Angeles. (Salary according to prevalent range in area) outstanding fringe benefits (near excellent educational facilities.) Let us tell you more about the opportunities to give patient-centered care. Contact office of: Director of Nursing, Santa Monica Hospital, 1250-16th Street, Santa Monica, California.

General Duty Staff Nurses for 450-bed fully approved hospital. Salary range per mo., day duty $419-$438: P.M. & night duty $429-$448, 40-hr. wk., paid vacation, 7 paid holidays per year, accumulative sick time based on length of service, liberal hospitalization plan, nurses' residence, rooms at reasonable rates. Registration or Permit to work in California required. Address applications to: Chief Nurse, Southern Pacific Railroad Hospital, San Francisco 17, California.

MISCELLANEOUS

General Duty Nurses (2) Certified Aide (1) for modern 20-bed hospital, excellent personnel policies, renovated separate residence. Full particulars apply to: Matron, Municipal Hospital, Myrnam, Alberta.

Registered Nurses, (1) experienced Operating Room Nurse & Certified Nursing Assistants for new 70-bed hospital. Salary $300-$330: $200-$230. Liberal policies, 40-hr. wk. apply: Sister Superior, Providence Hospital, High Prairie, Alberta.

General Duty Registered Nurse for 25-bed hospital, starting salary $290 per mo., 1-mo. vacation with pay after one year service, board, room & laundry available. Full particulars apply to: Matron, Municipal Hospital, Raymond, Alberta.

Registered Nurses for 50-bed hospital. Full maintenance $35, salary equivalent to Alberta Associated Hospitals of Alberta. Bus & train service to Calgary & Edmonton. Apply: Matron, Innisfail Municipal Hospital, Innisfail, Alberta.

Registered Nurses (2 immediately) for 32-bed hospital, salary $325 per mo., 40-hr. wk., 10 legal days with pay, 1½ days sick leave per mo., 21 days vacation after 1-yr., living accommodation at hospital $35 per mo. Valuable experience available. Good boating, fishing & swimming, beautiful scenery overlooking the mighty Peace River, also skating & picture shows. Fare from any place in Canada could be advanced & need not be repaid if you stay over six (6) months. Return fare paid after 1½ years. Kindly apply giving experience & references to: Director of Nursing, Sister Priscilla Marie, St. Theresa Hospital, Fort Vermilion, Alberta.

Matron (1) with knowledge of X-Ray & (2) **General Duty Nurses** (immediately) for 15-bed hospital, 40-hr. wk., statutory holidays, standard B.C. wages, regular vacation, room & board available in hospital $40 per mo., beautiful location. Apply with full particulars, Administrator, Arrow Lakes Hospital, Nakusp, British Columbia.

Registered Nurse (English) plans a slow camping trip via Los Angeles, Grand Canyon Yellowstone, Duluth, Fort William to Toronto or Seaboard. Starting point Victoria, date early August. Car Vauxhall Velox. Reliable. Interests, rock collection & photography, & would like to meet another to share expenses & driving. Apply: Miss A. Binney, 1740 Fort Street, Victoria, British Columbia.

Registered Nurses (2) 25-bed hospital near Winnipeg. Salary $315 respectively, 40-hr. wk., vacation pay, 10 statutory holidays, room & board $45, $10 increment, yearly, Registered Nurse (1) with supervisory experience to assume duties of Director of Nursing, immediately, commencing salary $360. Apply to: Administrator, DeSalaberry Hospital District No. 27A, St. Pierre, Manitoba.

Director of Nursing for a modern 45-bed hospital in Carbonear, Newfoundland. Duties to commence August 1st 1962, accommodation provided in modern residence. Salary scale $3,655-$3,980 per annum. Apply giving particulars to: Medical Superintendent, Carbonear Community Hospital, Carbonear, Nfld.

JEWISH GENERAL HOSPITAL

MONTREAL QUE.

NURSING OPPORTUNITIES

In this modern 400-bed non sectarian hospital in Administration, Teaching, Staff Nursing. Certified Nursing Assistants also required. Openings in Psychiatry, Pediatrics, Obstetrics and Medicine and Surgery. Excellent personnel policies. Bursaries for post-basic courses in Teaching and Administration.

For further information, please write:
DIRECTOR OF NURSING, JEWISH GENERAL HOSPITAL, 3755 COTE ST. CATHERINE ROAD, MONTREAL, QUE.

NURSING INSTRUCTOR

Candidates with degree preferred but consideration will be given to an experienced person with certificate in teaching and supervision.

Primary teaching responsibility — *Science.*

The Science program is an integrated one; gives basic material in the classroom and group teaching.

The Science Instructor assists teachers in the Clinical field to develop and apply these concepts.

Student enrollment — 95.

Inquiries regarding this position should be addressed to:

PERSONNEL DIRECTOR
SARNIA GENERAL HOSPITAL
SARNIA, ONTARIO

CLINICAL INSTRUCTOR IN FUNDAMENTALS OF NURSING

required for
SASKATOON CITY HOSPITAL SCHOOL OF NURSING
SASKATOON, SASK.

One class of approximately 60 students enrolled annually. Course begins January 1, 1963. Adequate time for orientation and preparation for classes will be arranged.

Please apply to:
DIRECTOR OF NURSING, SASKATOON CITY HOSPITAL SCHOOL OF NURSING,
SASKATOON, SASKATCHEWAN.

WANTED IMMEDIATELY REGISTERED NURSES

FOR 35-BED HOSPITAL

Salary $305 with annual increments, allowance for experience and postgraduate training, 40 hour week — 9 statutory holidays, 3 week vacation after one year — 4 weeks thereafter, 1 day sick leave per month accumulative, generous fringe benefits, nurses' residence—board $45 per month.

Apply: LITTLE LONG LAC HOSPITAL, GERALDTON, ONTARIO.

PUBLIC HEALTH NURSES

REQUIRED FOR HEALTH BRANCH, B.C. CIVIL SERVICE

Positions available for qualified Public Health Nurses in various centres in British Columbia. SALARY — $356 - $440 per month; car provided. An opportunity for interesting and challenging professional service in this beautiful and fast-developing Province. For further information and application forms, apply to The Director, Public Health Nursing, Department of Health Services and Hospital Insurance, Parliament Buildings, VICTORIA, B.C., or to The Chairman, B.C. Civil Service Commission, 544 Michigan Street, VICTORIA, B.C. COMPETITION NO.62:57.

PUBLIC HEALTH NURSE (QUALIFIED)

For Generalized Program
TOWN OF NEW TORONTO, ONTARIO

Starting salary range — $3,700 to $4,300 (depending upon experience)

5 day week. Pension benefits, sick leave plan. Ontario Hospital & P.S.I.

Car allowance provided. Starting date: September 1st, 1962.

Apply: J. H. MILLER, CLERK,
TOWN OF NEW TORONTO, 185 FIFTH STREET, TORONTO 14, ONTARIO

NURSING INSTRUCTOR

DEPARTMENT OF VETERANS AFFAIRS, FOR CAMP HILL HOSPITAL, HALIFAX, N.S.
Applications are invited from Nurses registered in a province of Canada who hold a certificate in Teaching and Supervision or Nursing Administration from a university of recognized standing and have four or more years of experience some of which has been in a teaching or supervisory capacity.
SALARY — $4,380 - $4,920
For further details and application forms write to
CIVIL SERVICE COMMISSION OF CANADA, OTTAWA.
Please ask for Information Circular 62-494.

CANADIAN NURSES' ASSOCIATION

has interesting positions in association work for:
— Registered Nurse with experience in nursing and degree qualification
— professional writer with skill in public relations techniques.

Apply: EXECUTIVE DIRECTOR
CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA 2, CANADA

MISCELLANEOUS

Head Nurse & Assistant Head Nurse (Applications are invited) Vacancies pending. Starting salary dependent upon qualifications & experience. Head Nurse $335 - $345; Assistant Head Nurse, $325 - $335, excellent personnel policies, residence accommodation available. Apply: Director of Nursing, The Queen Elizabeth Hospital, 130 Dunn Avenue, Toronto, Ontario.

Public Health Nurse for Haldimand County School Health Service, starting September 1962. Salary $3,900 plus $700 car allowance. Direct inquiries to: Mr. Morley Haller, 322 Caithness Street East, Caledonia, Ontario.

Matron for 8-bed hospital in southern Sask. Salary range $358-$453, qualifications & experience considered, duties to commence Sept. 1/62, 3-wk. vacation plus statutory holidays, 40-hr. wk. Apply to: Mrs. D. L. Knops, Secretary-Treasurer, Union Hospital, Rockglen, Saskatchewan.

Graduate Nurse, Staff Duty for 100-bed acute County Hospital J.C.A.H. accredited, located in San Joaquin Valley midway between San Francisco & Los Angeles, 40-hr. work wk., sick leave, 3-wk. paid vacation, 12 holidays, a career employment, salary $358 - $415 depending on experience & recommendations, plus shift differential, rooms available in modern nurses' residence at $10 per mo., within 2 hours drive of ocean, mountain or desert resort areas. Write, wire or phone: Director of Nursing, County Hospital, Tulare, California.

NURSING CONSULTANT

Required for

SANATORIUM BOARD OF MANITOBA

operating 5 hospitals for Rehabilitation and Physical Medicine, Extended Treatment, and Tuberculosis, respectively.
Responsible for:

1: Nursing Services and quality of nursing care.

2: Development of in-service education programs.

3: Consultation at executive level on all aspects of nursing administration.

Salary according to experience and qualifications.

Appointment for August 1st or earlier.

Apply to:

EXECUTIVE DIRECTOR
SANATORIUM BOARD OF MANITOBA
800 SHERBROOK STREET, WINNIPEG 2, MANITOBA

REGISTERED NURSES
NURSING ASSISTANTS

Required for all departments in new 163-bed hospital, centrally located between Toronto and Hamilton, in a very progressive community.

Good salary and personnel policies, pension plan, 40-hour week.

Apply stating age, qualifications to:

DIRECTOR OF NURSING,
OAKVILLE-TRAFALGAR MEMORIAL HOSPITAL, OAKVILLE, ONTARIO

ASSOCIATE DIRECTOR OF NURSING SERVICE

225-BED GENERAL HOSPITAL — FULLY ACCREDITED WITH SCHOOL OF NURSING

Good personnel policies

Salary commensurate with preparation & experience

For further information apply to:

DIRECTOR OF NURSING
PRINCE EDWARD ISLAND HOSPITAL
CHARLOTTETOWN, P.E.I.

OPERATING ROOM NURSES

For 163-bed active hospital, located in a progressive community between Toronto and Hamilton. Postgraduate training or experience essential. Good salary and personnel policies.

Apply giving age, qualifications and experience to:

DIRECTOR OF NURSING
OAKVILLE-TRAFALGAR MEMORIAL HOSPITAL
OAKVILLE, ONTARIO

CLINICAL INSTRUCTOR

in

MEDICAL AND SURGICAL NURSING

Required for 300-bed General Hospital. Modern classrooms and facilities. Present student enrolment — 95.

Minimum qualifications — Diploma in Nursing Education, Degree preferred. This is an excellent opportunity for the successful candidate to use progressive techniques in teaching.

Apply:

PERSONNEL DIRECTOR, SARNIA GENERAL HOSPITAL, SARNIA, ONTARIO

THE SCHOOL OF NURSING

BROCKVILLE GENERAL HOSPITAL, BROCKVILLE, ONT.

Invites applications for — Instructor

Requirements: University preparation in Nursing Education

Salary differential for degree

Apply to:

DIRECTOR OF NURSING

ST. JOSEPH'S HOSPITAL

HAMILTON, ONTARIO

Opening Large Modern Addition — Autumn, 1962 — 900-bed capacity.

Nursing facilities, both attractive and efficient, await the professional graduate nurse. A Six-Million Dollar expansion provides for a new air-conditioned building, with modern Admitting Wing, Emergency Unit, Operating and Recovery Rooms, Intensive Care Unit, Patient Rooms, Wards and Play Areas, enlarged Laboratories and a New Dining-Room for the personnel.

Orientation and Active In-Service program. Clinical areas for Student Nurses and Medical Interns.

The City of Hamilton is within easy access to the Niagara Peninsula and United States.

Positions available in all clinical areas.

For further information write:

DIRECTOR OF NURSING, ST. JOSEPH'S HOSPITAL, HAMILTON, ONTARIO

REGISTERED NURSES
REQUIRED FOR DVA HOSPITALS

Salaries in accordance with accepted practice in the locality as indicated below. A higher rate may be paid for recent acceptable experience. Specialty allowances will be paid for postgraduate training or education which is utilized in the performance of the duties of the position.

Victoria Veterans Hospital, Victoria, B.C. ($3,600)
Shaughnessy Hospital, Vancouver, B.C. ($3,600)
Colonel Belcher Hospital, Calgary, Alta. ($3,450)
Deer Lodge Hospital, Winnipeg, Man. ($3,450)
Westminster Hospital, London, Ont. ($3,450)
Sunnybrook Hospital, Toronto, Ont. ($3,450)
Queen Mary Veterans Hospital, Montreal, P.Q. ($3,300)
Ste. Anne Veterans Hospital, Ste. Anne de Bellevue, P.Q. ($3,300)
Lancaster Hospital, Lancaster, N.B. ($3,150)
Camp Hill Hospital, Halifax, N.S. ($3,000)

BENEFITS:

Pension plan; three weeks' paid vacation; three weeks' cumulative sick leave; five day week. Cotton uniform and laundering of same will be provided. In some centres low cost living in staff residences is also available.

Applications are available at Civil Service Commission Offices, National Employment Offices and main Post Offices.

For further particulars contact the Civil Service Commission Office in the province where the position in which you are interested exists:

VANCOUVER, 1110 Georgia St. W., EDMONTON, 107 St. & 99 Ave., WINNIPEG, 266 Graham Ave., TORONTO, 25 St. Clair Ave. E., MONTREAL, 1165 Bleury St., SAINT JOHN, Canterbury St., HALIFAX, 105 Hollis St.

OPERATING ROOM SUPERVISOR
required

for 66-bed accredited hospital, excellent opportunity for Registered Nurse with P.G. course or extensive O.R. experience. Border town, 10 minutes from downtown Buffalo.

Apply: Director of Nursing

DOUGLAS MEMORIAL HOSPITAL, FORT ERIE, ONTARIO.

VICTORIAN ORDER OF NURSES FOR CANADA
has Staff and Supervisory positions in various parts of Canada.

Personnel Practices Provide:

- Opportunity for promotion.
- Transportation while on duty.
- Vacation with pay.
- Retirement annuity benefits.

For further information write to:

Director in Chief,
Victorian Order of Nurses for Canada
5 Blackburn Ave., Ottawa 2, Ontario

Wanted by the City of Hamilton — PUBLIC HEALTH NURSE

Must be a graduate Nurse and should have the Public Health Certificate.
5 day — 36¼ hour week. Minimum salary $3,701 — Maximum salary $4,457.
Starting salary commensurate with previous experience.
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